Issuance Date: October 14, 2008
Closing Date: Hard copies: November 17, 2008

Closing Time: 5:00 PM. Local Nairobi, Kenya time

Subject: RFTOP 650-09-313 **for:**

SUDAN HEALTH TRANSFORMATION PROJECT – PHASE 2 (SHTP 2)

To: IQC Holders under TASC III
From: Patrick Kollars, Contracting Officer USAID Sudan

Subject: Request for Task Order Proposals (RFTOP)

Dear Sirs/Madams

Enclosed is a Statement of Work for a proposed Cost Plus Fixed Fee (CPFF) Task Order to be issued under the referenced Indefinite Quantity Contract (IQC) subject to the availability of funds. Appendices and reference materials related to this RFTOP are available for download at: http://ghiqc.usaid.gov/tasc3/index.html

Prospective Offerors are requested to confirm that they have received the Instructions, Statement of Work, and Evaluation Criteria, and that all relevant appendices and reference material can be downloaded.

If your organization is interested in submitting a Proposal in response to this RFTOP, please carefully review this letter and the contents of this request, which include:

Section	Title
Section A	Statement of Work
Section B	Instructions for Preparation of the Proposal
Section C	Evaluation Criteria

It is anticipated that a three year Task Order (TO) will be awarded for these services. This TO will be USAID/Sudan's primary mechanism to achieve results in the Health Program Area of the Investing in People strategic objective. The TO will achieve results related to the following Program Elements: 3.1.1 HIV/AIDS, 3.1.3 Malaria, 3.1.6 Maternal & Child Health, and 3.1.7 Family Planning & Reproductive Health.

The TO will have two primary components: i) delivery of high impact primary health care (PHC) and selected HIV/AIDS services; and ii) strengthening decentralized health services to further implementation of Sudan's Comprehensive Peace Agreement. The work will build on previous USAID investments in

primary health care and HIV/AIDS services, and shall include provision for continued support via subcontracting to several "lead agency" NGO partners currently funded via an existing USAID Sudan Cooperative Agreement.

Proposals should be prepared in accordance with Section B, **Instructions for Preparation of the Proposal.**

Technical questions and requests for clarifications should be sent via email to: pkollars@usaid.gov and will be accepted until **5:00 PM October 21th, 2008**. (Khartoum, Sudan local time). Responses to questions and requests for clarification will be returned to all IQC holders as quickly as possible to allow adequate time for final proposal preparation.

Final proposals should be submitted to USAID East Africa in Nairobi Kenya. Please see Section B1 Preparation of the Proposal for specific instruction regarding hard copy submission. All hard copies should be received at the following address by **5:00 PM November 21st, 2008**. (Nairobi, Kenya local time).

By courier:

Marcus Johnson
USAID/East Africa
C/O American Embassy
United Nations Avenue, Gigiri,
Nairobi, Kenya

Proposals should be prepared in accordance with the Instructions contained in Section B of the RFTOP documents, and will be evaluated in accordance with Section C Evaluation Criteria. Prospective bidders should request confirmation that their final proposals have been received by the closing date and time specified. USAID shall not be held responsible for incomplete or partial submissions. Proposals received after the closing date and time specified will be considered late and shall not be evaluated (FAR 15.208)

Issuance of this RFTOP does not constitute an award commitment on the part of the U.S. Government, nor does it commit the U.S. Government to pay for costs incurred in the preparation and submission of Proposals. Further, the U.S. Government reserves the right to reject any or all Proposals received.

Award of the Task Order contemplated by this RFTOP cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award. Proposals are submitted at the risk of the offeror.

Thank you for your consideration of this USAID initiative. We look forward to your organization's participation.

Sincerely,

Patrick Kollars
Contracting Officer
USAID Sudan

Acronyms List

AB	Abstinence and/or Being Faithful
ABC	Abstinence, Be Faithful, and correct and consistent Condom use
ACT	Artemisinin Combination Therapy
ADS	Automated Directive System
AIDAR	Agency for International Development Acquisition Regulation
ANC	Ante-natal Care
APS	Annual Program Statement
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
BRIDGE	Building Responsibility for the Delivery of Government Services
CBO	Community Based Organization
CDC	U.S. Centers for Disease Control and Prevention
CDIE	Center for Development Information and Evaluation
CHD	County Health Department
CO	Contract Officer
CONUS	Continental United States
COP	Chief of Party
COP	Country Operational Plan
CPA	Comprehensive Peace Agreement
CTO	Cognizant Technical Officer
CV	Curriculum Vitae
CYP	Couple Years of Protection
DPA	Darfur Peace Agreement
DPT3	Diphtheria-Pertusis-Tetanus (3 doses)
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
ESPA	Eastern Sudan Peace Agreement
FANTA	Food and Nutrition Technical Assistance
FAR	Foreign Assistance Regulations
FBO	Faith-based Organization
FM	Financial Management
FP	Family Planning
GAVI	(formerly) The Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoSS	Government of Southern Sudan
GoSS/MoH	Government of Southern Sudan/Ministry of Health
GUC	Grants Under Contract
HEAR	Health, Education and Reconciliation Creative Associates
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSS	Health System Strengthening
IDP	Internally Displaced Person
IEC	Information-Education-Communication

IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment
IQC	Indefinite Quantity Contract
ITN	Insecticide Treated Net
LAM	Lactation Amenorrhea Method
LLITNs	Long-lasting Insecticide Treated Nets
LMS	Leadership, Management & Sustainability
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHIP	Mother and Child Health Immunization Project
MCHW	Maternal and Child Health Worker
MDTP	Multi-Donor Trust Fund
MMR	Maternal Mortality Ratio
MSF	Medicins Sans Frontiers
MYAP	Multi-Year Assistance Program
N/A	Not Applicable
ND	No Data
NGO	Non-governmental Organization
NICRA	Negotiated Indirect Cost Rate Agreement
NIH CPS	National Institutes of Health Contractor Performance System
NR	Not Relevant
NTE	Not to Exceed
o/a	on or about
ODC	Other Direct Costs
OFDA	Office of Foreign Disaster Assistance
ORS	Oral Rehydration Solution
PBF	Performance-based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
PITC	Provider-initiated Testing and Counseling
PL	Public Law
PLWHA	People Living with HIV/AIDS
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
QA/QI	Quality Assurance/Quality Improvement
RFTOP	Request for Task Order Proposal
RH	Reproductive Health
RTC	Regional Training Centers
SDM	Standard Days Method
SDP	Service Delivery Point
SHHS	Southern Sudan Household Health Survey
SHTP1	Sudan Health Transformation Project-1
SHTP2	Sudan Health Transformation Project-2

SMoH	State Ministries of Health
SOW	Scope of Work
STI	Sexually Transmitted Infection
TA	Technical Assistance
TASC3	Technical Assistance and Support Contract
TBA	Traditional Birth Attendant
TB-CAP	Tuberculosis Control Assistance Program
TBD	To Be Determined
TDY	Tour of Duty
TO	Task Order
TOCO	Task Order Contracting Officer
TT	Tetanus Toxoid
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
USAID/FFP	U.S. Agency for International Development/Food For Peace Program
USAID/Sudan	United States Agency for International Development's Mission in Sudan
USG	United States Government
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WASH	Water, Sanitation, and Hygiene
WFP	World Food Program
WHO	World Health Organization

SECTION A – STATEMENT OF WORK

I. BACKGROUND

Sudan is the United States Government's (USG) highest foreign policy priority in Africa. Given this priority, well before the signing of the Comprehensive Peace Agreement (CPA) in 2005 USAID worked with members of the nascent Government of Southern Sudan (GoSS) at its base in Nairobi to lay out the most critical investments and needs for the new government. One of the most pressing needs was bringing health care to a population decimated by almost 50 years of war. Sudan's health indicators were – and remain – among the worst in the world. As of 2006, or two years after the CPA, infant mortality was 102 per 1000 live births; mortality for children under 5 years of age was 135 per 1000; and maternal mortality was an astounding 2,037 per 100,000 births. In 2004, due to the war there was almost a total lack of health system infrastructure, equipment, materials, and – most critically – trained human resources. The need was to urgently provide primary health care services to the population, while at the same time creating almost from scratch a functioning public health care system in Southern Sudan that could provide those services over time. Meeting the two critical needs was, and remains, a careful balancing act.

USAID launched the five-year Sudan Health Transformation Project (SHTP1) in April 2004, before the signing of the CPA. Initial planning was carried out with the nascent Secretariat for Health in Nairobi prior to the return to Southern Sudan. What health care that existed in the Southern then-three provinces (now 10 states) was undertaken by a patchwork of faith-based organizations (FBOs) and humanitarian NGOs, with no guiding framework or oversight. Given the extreme paucity of trained Sudanese in the south, the GoSS/MoH decided to take the patchwork and create a model of public-private partnership, where the FBO/NGO partners would provide services in defined geographic areas under agreement with the government, while the government geared up support policies, protocols, and systems.

The SHTP1 has been a key partner in the reestablishment of the health system. It has provided high impact health services through a network of lead NGO partners in selected underserved counties in Southern Sudan, while at the same time providing highly valued support to the GoSS/MoH in creating a basic public health policy framework. The support ranged from technical assistance to develop important policies and guidelines, to creation of basic patient logs and commodity registers at the service delivery points. Personnel training has been a priority – but was necessarily preceded by development of protocols and standards, syllabi, curricula, training materials, and rehabilitation of five health training centers. There is still a very long way to go, but the basic foundations of a primary health care system in selected areas are in place, and USAID and SHTP1 have contributed significantly to that process.

SHTP1 will end in 2009. The CPA is in force and milestones are being met. The GoSS/MoH has established many of the prerequisites for a health system, but coverage is still very low, with only 25% of the population assumed to have access to health care and still-fragile systems to

support service delivery. Much of the "transformation" foreseen in the original project title has indeed taken place, but more remains to be accomplished. There is particular need to mobilize communities to engage in community-based health preventative and basic health services, and to strengthen the critical County Health Departments (CHDs) to provide oversight and supervision of lead NGO service providers. Continuous engagement of health cadres, through in-service training, facilitative supervision, and provision of job aids, will continue to be a high priority. Although many of the policies and guidelines have now been prepared, they need to be disseminated and the practices rolled-out to the health cadres and communities they serve.

In consultation with the GoSS/MoH, USAID plans to fund a second generation Sudan Health Transformation Project, hereinafter called SHTP2. The "second generation" takes full account of the struggles and gains of the first five years, and will build on the achievements made. SHTP2 will also include new emphases on some of the areas highlighted above, and will emphasize performance-based accountability in all areas.

This document provides an overview of the major health and development issues in Sudan and describes the requirements and standards that need to be accomplished in order to achieve new results under SHTP2. Applicable documents are referenced throughout this performance work statement describing in detail the efforts that USAID and other stakeholders have pursued in the last several years to improve access to primary health care services.

The assessment of the Sudan Health Transition Program – Phase 1 (SHTP1) reported that as of the end of 2007, SHTP1 partners had initiated high impact services at 99 service delivery points (SDPs) in 6 counties in 6 states in Southern Sudan. Since that time SHTP1 has awarded agreements to an additional 3 partners in 3 additional counties. As of July 2008, SHTP1 was supporting 25 Primary Health Care Centers (PHCC) and 120 Primary Health Care Units (PHCU), for a total of 145 SDPs covering about 1.6 million people, or about 12% of Southern Sudan's estimated population of 12.5 million. By March 2009, it is expected that SHTP1 will have partners in an additional 3 counties, for a total of up to 12 counties, reaching over 2.3 million people. With reference to Figure 1 below, it is intended that through this procurement, an expanded range of high impact services will be continued at the current 145 SDPs, plus at least 12 facilities in the 3 new counties, and that by 2011, no less than 80% of the population in focus counties will utilize at least one of these high impact services.

Figure 1: Basic Information on SHTP1-Assisted Counties

State	SHTP1-Assisted County	County Population[1]	SHTP1 Lead NGO	Functional County Health Facilities	HIV VCT or PITC	Antenatal care attendance (≥ 1 visit)[2]	
						#	%[3]
Jonglei	Twic East	136,000	Care Internat'l	No CHD 2 PHCC (all SHTP1) 13 PHCU (all SHTP1)	0	708	57.6%
Unity	Panyijar	114,729[4]	Internat'l Rescue Committee	1 CHD 1 PHCC (SHTP1) 8 PHCU (all SHTP1)	0	310	12.9%
Western Equatoria	Tambura	100,866	Internat'l Medical Corps	1 CHD (5 members) 5 PHCC (all SHTP1) 21 PHCU (all SHTP1)	1 VCT + PITC	330	14.9%
Western Equatoria	Mvolo	215,162	Save the Children-USA & Sudan Internat'l Dev. Fund	1 CHD 3 PHCC (all SHTP1) 15 PHCU (all SHTP1)	1 VCT	499	29.1%
Western Equatoria	Mundri	125,492	Action Africa Help Interna'l	1 CHD 4 PHCC (all SHTP1) 32 PHCU (all SHTP1)	4 VCT	276	15.3%
Warrap	Tonj South	300,000	World Vision Internat'l	1 CHD 2 PHCC (all SHTP1) 7 PHCU (all SHTP1)	0	42	1.6%
Upper Nile	Malakal	105,000	Internat'l Medical Corps	1 CHD 4 PHCC (all SHTP1) 8 PHCU (all SHTP1)	0	NR[5]	NR
Northern Bahr el-Ghazal	Aweil South	336,000	Tearfund	1 CHD 2 PHCC (all SHTP1) 4 PHCU (all SHTP1)	0	915	29.3%
Central Equatoria	Terekeka	250,000	African Medical Research Foundation	1 CHD 2 PHCC (all SHTP1) 12 PHCU (all SHTP1)	0	288	10.2%
Central Equatoria	Juba	110,134	Internat'l Medical Corps	1 CHD 1 PHCC (SHTP1)[6] 3 PHCU (SHTP1)[6]	0[7]	NR[5]	NR
Western Bahr el-Ghazal	Wau	248,288	Internat'l Relief & Development	1 CHD 1 PHCC (SHTP1)[6] 3 PHCU (SHTP1)[6]	0[7]	NR[5]	NR
Eastern	Kapoete	295,000	Save the	No CHD	0	NR[5]	NR

[1] Population figures based on 2004 Starbase Population Data for Southern Sudan and information from local Authorities. These figures are predicted to increase as much as 30% per year as a result of post-war returnees.
[2] Figures are for most recent reporting quarter: April – June 2008
[3] % of pregnant women (April – June)
[4] Population figure for the entire county (SHTP1 provides services in one of the two districts in this county)
[5] Programming either has not begun, or is still in start-up phase
[6] These counties have more health facilities than are listed, but these numbers indicate the numbers to be supported under SHTP1
[7] No VCT or PICT services provided by SHTP1 (other NGOs are providing HIV services in these urban areas)

Equatoria			Children - USA	1 PHCC (SHTP1) [6] 3 PHCU (SHTP1) [6]			
TOTALS	**12 counties**	**2,336,671**	**-**	**10 Functional CHD 28 PHCC 129 PHCU**	**6 VCT in 3 cnties**	**3368**	**18.8%**
Legend: CHD = County Health Department PHCC = Primary Health Care Center PHCU = Primary Health Care Unit				VCT = Voluntary Counseling and Testing PITC = Provider Initiated Counseling & Testing **Source: SHTP1 Records July 2008**			

II. RELEVANT ASSESSMENTS, POLICIES AND ANNEXES

This project takes into account policies and strategies of the GoSS as well as "best practices" by USAID and other donors and partners pursuing improvements in primary health care and HIV/AIDS services in Southern Sudan. A full compendium of relevant documents is available in annexes posted at http://ghiqc.usaid.gov/tasc3/index.html website. A summary of the major and supplementary annexes and websites links are found below.

Major Annexes:

A. Health Policy for the Government of Southern Sudan 2006-2011, Ministry of Health, Government of Southern Sudan, Reviewed Version 2007.

B. Sudan Health Transformation Project (SHTP) Assessment Report, USAID/Washington, March 2008.

C1. SHTP Health Facilities Map, December 2007.

C2. USAID Southern Sudan Health Sites by County Maps, 2007.

C3. List of Current & Future SHTP Counties with Number of Facilities, Borehole and Latrines, 2007.

C4. USAID Current Health & Education Activities in the Border States, July 2008.

C5. USAID Southern Sudan Facilities Database, December 2007.

D. USAID BASICS Development Transition Gap Analysis of Health Facilities in Southern Sudan, BASICS, March 2008.

E. USAID and US State Department Strategic Plan Fiscal Year 2007 – Fiscal Year 2012: http://www.usaid.gov/policy/coordination/stratplan_fy07-12.pdf

F. Basic Package of Health & Nutrition Services for Southern Sudan, Ministry of Health, Government of Southern Sudan, Second Draft - March 2006.

G. Information on USAID/Sudan programs is available at http://www.usaid.gov/locations/sub-saharan_africa/countries/sudan/

H. Sudan Gender Assessment, USAID/East Africa, March 2003.

I. Guidance available at http://pepfar.gov/guidance President's Emergency Plan for AIDS Relief (PEPFAR), with particular attention to: ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use) Indicators Reference Guide for Focus Countries and All Bilateral Programs (Updated July 2007).

J. Building an Equitable Health System for Southern Sudan: Options for GAVI HSS Funding Report, July 2007.

K. Southern Sudan Household Health Survey (SHHS) Report Findings PowerPoint presentation, GoSS, October 2007.

L. Senator Paul Simon Water for the Poor Act of 2005: Report to Congress, U.S. Department of State, June 2006.

M. Southern Sudan HIV/AIDS Strategic Framework (2008-2012) - Draft, Government of Southern Sudan, 2008.

N1. Southern Sudan Maternal and Reproductive Health Rapid Assessment, USAID/Sudan, November 2007.

N2. Working Toward the Goal of Reducing Maternal & Child Mortality: USAID Programming & Response to FY08 Appropriations, USAID/Washington, and July 2008. Refer to pages 64-66 for Sudan MCH Program Description and indicators.

N3. Draft Maternal, Neonatal & Reproductive Health Strategy, GoSS MOH, October 2007.

N4. Southern Sudan Health System Assessment

Supplemental Annexes:

O. Southern Sudan Household Health Survey (SHHS) Report, GoSS, 2006.

P. Southern Sudan Household Health Survey (SHHS) Report Indicators and MDG Goals, GoSS, 2006.

Q. "Water: Unifying theme for multi-sectoral programs in Madagascar" Fara Raharisolo, USAID/Madagascar, PowerPoint presentation, Africa State-of-the-Art Health Managers' Meeting, March 2008.

R. "Southern Sudan Water Supply, Sanitation & Hygiene in Post-Conflict Settings: An Integrated Approach", Martin Swaka, USAID/Sudan, PowerPoint presentation, March 2008.

S. USAID Child Survival & Health Guidance, Fiscal Year (FY) 2004 Update.

T. 2008 USAID Operational Plan Custom Health Indicators.

U. List of Standard Indicators for Use in USAID FY 2008 Operational Plans.

V. USAID Health-Water technical guidance for FY 2008 Operational Plans.

W. 2008 USAID Water Earmark Guidelines.

X. Standard Program Definitions and Elements for USAID BRIDGE APS, July 2008.

Y. USAID Performance Management Plan, Health Section, October 2007.

Z. Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations, 2008:
http://www.usaid.gov/our_work/global_health/mch/publications/mch_report.html

Offerors are also encouraged to look at relevant UN and other donor websites for Sudan-specific information, e.g. World Bank, WHO, and UNICEF.

III. SUDAN PROGRAM BACKGROUND

As stated above, Sudan is the United States Government's (USG) highest foreign policy priority in Africa. The USG program addresses the challenges of consolidating fragile peace agreements and supporting post-conflict reconstruction, critical concerns of counter-terrorism and regional stability, the scale of gross human rights abuses still being perpetrated, and the ongoing need for life-saving humanitarian assistance. The historical concentration of wealth and power in the central government at the expense of the marginalized majority has been one of the main drivers of conflict in Sudan for much of the last 50 years. The 2005 Comprehensive Peace Agreement (CPA) officially ended a 21-year war between north and south, but much remains to be done given the continued high level of political, economic, and social instability in southern Sudan. The nascent Government of Southern Sudan (GoSS) remains institutionally weak and authorities in Khartoum continue to inadequately demonstrate the political will to implement the CPA, especially the Abyei Protocol and transparency in revenue sharing. Violence and atrocities continue to plague civilians in Darfur, in spite of the 2006 Darfur Peace Agreement (DPA); and the potential for conflict lingers in the East due to the tenuous Eastern Sudan Peace Agreement (ESPA) also negotiated in 2006. For these reasons, Sudan will remain a "Rebuilding" country, and the USG will continue to provide targeted assistance based on policy goals and geographic realities that help advance all five Foreign Assistance Framework objectives to which USAID contributes. (see http://www.usaid.gov/policy/coordination/stratplan_fy07-12.pdf for the full USG Strategic Plan).

Consolidating the CPA is vital to USG interests in ensuring a transition to a stable, democratic government for all parts of Sudan, promoting regional stability, and continuing effective counter-

terrorism cooperation. Assistance for recovery and reconstruction, as well as humanitarian aid for returnees, will continue to provide a tangible peace dividend, and USG will continue to enhance an environment for peace regardless of the outcome of the 2011 referendum. Support will focus on war-affected regions to facilitate economic recovery and governing more justly. USG strategy emphasizes investment in community development and essential services to reduce tensions rebuild communities and encourage and sustain the return of displaced people.

IV. HEALTH SECTOR CONTEXT

A. **Overview**

Sudan, especially in the South and Three Areas, faces formidable health challenges as it rebuilds after decades of civil war. Childhood deaths due to infectious diseases are rampant (the Infant Mortality Rate (IMR) is 102.4 per 1000, Vitamin A deficiency affects one of seven children in Sudan. DPT3 immunization among children is under 18%. Maternal mortality rates are among the highest in the world, the Maternal Mortality Ratio (MMR) ranges from 1000 to 2000 per 100,000 (2006 HHS); reproductive health is poor due to lack of access to skilled antenatal care providers (the proportion of births attended by skilled health staff is also among the lowest in the world); the fertility rate is 5.9 live births per woman (UNICEF), and rates of modern family planning use are low in Southern Sudan and. 94% of births take place at home. HIV/AIDS is an emerging threat due to risky sexual behaviors and Sudan's proximity to the regional pandemic. Water and sanitation infrastructure is non-existent or marginal at best, and sanitation and hygiene practices are poor. A wide range of 'tropical' diseases that are controlled elsewhere are endemic in Southern Sudan; many of these are also so-called 'neglected diseases'. Critical diseases in Sudan include tuberculosis, malaria, pneumonia and diarrhea. With few exceptions, population density is low, which remains an obstacle to both service provision and access to health care.

USAID and other bilateral governments have supported International and local NGOs who have played an important role in the delivery of health services in Southern Sudan during the war. UNICEF, WFP, UNFPA, UNDP, and WHO has played a major role among the UN agencies. Recently, the World Bank-assisted Multi-Donor Trust Fund (MDTF) with funding from other bilaterals and the GoSS is moving forward to contracting one "lead NGO" per state to implement the BPHS. The MDTF model is an adaptation from the SHTP1 model of lead NGO per county. This contracting mechanism is experimenting with some innovative elements for performance based results and forging NGO and public sector cooperation at the state level.

With the transition from emergency to sustainable health service delivery, attention is needed to address the fragmentation that has resulted from years of neglect in the health sector. Emergency response interventions were often disjointed and short term, inefficient, and the focus on first-level health services and disease specific programs – typical for humanitarian action. This has, understandably, overshadowed attention to building sustainable basic health systems and infrastructure, strengthening human capacity, and actively mobilizing and engaging civil society groups for decision making around their own health. Shortage of skilled human resources has been – and is – one of the major limiting factors to providing basic health care. The GoSS Ministry of Health (MoH) advocates an integration of the existing vertical programs in the resource pool and in the management structures of the mainstream health system. The

GoSS/MoH Basic Package of Health Services (BPHS) Policy on five principles: right to health, equity, pro-poor, community ownership and good governance. The main criteria for the choice of services were the ones that would have the greatest impact on the health of the population, that would be equally accessible to the largest possible part of the population and be affordable on the short run and sustainable on the long run.

The BPHS for Southern Sudan includes curative, preventative, managerial and health promotion activities, whether provided by the GoSS/MoH, State Ministries of Health (SMoH) or contracted out to implementing partners (Faith-Based Organizations or NGOs). The World Bank-assisted MDTF is assisting GoSS/MoH in decentralizing the management of services by strengthening the SMoHs by creating public/NGO partnerships to strengthen the implementation and monitoring of health services. The improved monitoring and supervision systems will increased accountability at all levels.

USAID/Sudan's strategy focuses on supporting the CPA by assisting the GoSS to provide peace dividends and address the factors that fuel conflict. Key to that process is interventions that will provide tangible peace dividends – e.g. health dividends -- and increase the confidence of the population in their government's ability to provide basic services. In addition, improving the overall health of the Sudanese people will enable citizens to become more productive, allowing education levels to advance, promote economic growth, and reinforce stability and peace.

Under this task order, USAID will build on its current health investments under SHTP1 where constructive, and may, subject to availability of funds, implement additional quick-impact activities in areas where high refugee and internally displaced person (IDP) returns increase pressure on limited existing services. Improving essential services will allow communities to rebuild and sustain the return of displaced people without igniting further conflict. The SHTP1 assessment confirmed that longer-term investments in the future are critical to continuing along the path of rebuilding Southern Sudan's basic health services. The future program will build on NGO efforts and deepen community and civil society participation in basic health care services.

Activities under this task order must demonstrate a focus on building County Health Department (CHD) capacity to oversee the delivery of high-impact health services/practices in coordination with other USG funded programs in the proposed area of operation. Successful applicants will be expected to participate in GoSS and other donor coordination efforts to reduce duplication, standardize approaches and support the implementation of the GoSS's decentralization of the health sector. This should result in an evident health dividend for the Sudanese population supporting the successful implementation of the CPA.

B. The Southern Sudan Health System

The Southern Sudan health system is based on four levels of administrative structure, the community (PHC unit, or PHCU), first referral (PHC center, or PHCC), second referral hospital, and the county health department (CHD). Progress has been made in some locations in establishing PHC structures, village health committees, delivering selected health services, and introducing cost sharing. However, overall, the system has critical constraints including a limited health budget with major imbalances in salaries and operating costs. This imbalance is skewed

to hospitals and urban areas, which has a relatively lower disease burden that the rural areas where the majority of the population lives. The drug logistics supervision and information system is fragile and principally managed by NGOs, with very limited training and capacity in this area. The community level covers only about 30 percent of the population in stable areas. Other than private pharmacies and unauthorized market drug tables in urban areas, there is a near absence of formal private sector medical care.

Since the signing of the CPA, the GoSS has developed nearly a dozen policies, strategies, curricula, cadre position descriptions and guidelines for implementing different sub-sectors within the health sector. The GoSS's BPHS guidelines available at the public website associated with this offer provides an excellent overview of the desired health care system. Other guidelines and policies include: Drug Logistics Management, Maternal and Reproductive Health, Family Planning Guidelines, Human Resource Management, Management Information Systems, National Malaria Strategic Plan. (See TASC3 website for some of these documents available in final form at the time of this solicitation) Work is underway to develop standard position descriptions for health cadres, a nutritional strategy and strengthen routine immunizations. Working with a range of NGOs/organizations offering health services and training throughout the country is a challenge. The GoSS has formed alliances with the NGO Forum for soliciting technical advice and regularly solicits guidance into formulating policies and programs to harmonize health services delivery as the government transitions from emergency to development. Current donors are working closely with the central GoSS/MoH to strengthen capacity in policy and strategic planning and with SMoHs to help build capacity for program implementation and management at the state level.

C. USG Investments in Health

For two decades, the USG has supported health humanitarian relief activities; and since 2004, health development activities. In the 2009 GoSS budget, nearly $300 million is budgeted for the health sector with both public and donor resources. Out of that USAID and OFDA are providing about $35 million-- making the USG is the single largest donor in the sector.

Figure 2: USG Investments in Health in Southern Sudan

Lead Office/Sector	Short Description	FY 08Funding Levels
Office of Foreign Disaster Assistance (OFDA)	OFDA focuses on areas affected by IDPs and/or conflict, mostly in Bahr el-Ghazal, Jonglei and Upper Nile. With reference to Figure 1, under this task order USAID plans to transition remaining current OFDA SDPs within USAID focus counties to sustainable health services under the relevant county's "lead NGO" partnership.	$16 million in health in FY07
USAID/Sudan Health Office	SHTP 1: 145 SDPs in 9 counties comprising 1.6 million people. Provision of high impact services and systems strengthening. Described in Section I and Figure 1 above.	$37 million FY2004-2008
USAID/Sudan	Multi-sectoral Building Responsibility for the Delivery of Government Services (BRIDGE) program will include water, sanitation and hygiene in the Three Areas and four border states (Warrap, Unity, Upper Nile, and Northern Barh el-Ghazal), as well as activities in democracy and governance, education, and livelihoods.	$10 million in FY08 Water funds and some MCH/FP as part of multi-sectoral initiative

USAID/Sudan Health and Education Offices	Multi-sectoral funding to the Health, Education and Reconciliation Creative Associates (HEAR) project to provide Vitamin A, deworming, and improved teaching methods supported by Interactive Radio Instruction and innovative health/education curricula to ensure that teachers and health workers are equipped to provide quality health and education to children.	Almost $500,000 for Health Education in schools in S. Kordofan, Blue Nile and Abeyi
USAID/Sudan through central Field Support	Focused technical assistance and training for tuberculosis diagnosis and control in Southern Sudan through the central Tuberculosis Control Assistance Program (TB-CAP).	$552,000
USAID/Sudan through central Field Support	Procurement of pharmaceutical commodities (ACT and IPT) and related logistics management support for GoSS Malaria Control Program through the central DELIVER mechanism	$1.1 million
USAID/Sudan through central Field Support	Focused technical assistance, training, and advocacy for child spacing/family planning through the central Leadership, Management & Sustainability (LMS) mechanism	$300,000
USAID/Sudan through central Field Support	Focused technical assistance and training for nutrition through the central Food and Nutrition Technical Assistance (FANTA) mechanism	$300,000
USAID/Sudan through central Field Support	Focused technical assistance and training for immunization through the central Mother and Child Health Immunization Project (MCHIP).	$416,000
USAID/Sudan through central Field Support	Support to the World Health Organization for polio eradication and disease surveillance, respectively, in Southern Sudan	$1.489 million Polio $800,000 surveillance
USAID/Sudan through central Field Support	Focused technical assistance and training for human resource development with the GoSS/MoH through the central Capacity Project.	$800,000
USAID/Sudan through central Field Support	Procurement of contraceptive commodities	$500,000
USAID/Sudan and the US Centers for Disease Control and Prevention (CDC)	HIV/AIDS prevention, care, treatment, and strategic information activities under the President's Emergency Plan For AIDS Relief (PEPFAR)	$9.5 million in FY08 ($6.5 million USAID, $3 million CDC)
USAID/East Africa	Activities to address domestic violence, conduct media advocacy to reduce gender-based violence, and conduct legislative advocacy in support of gender equity, male norms, and health care.	(no USAID/Sudan funding provided)

In addition, USAID/FFP provides food emergency food assistance and supplies, targeting refugees and IDPs, reaching about millions of beneficiaries. USAID also collaborates with the Department of State, Bureau for Population, Migration and Refugees, which provides estimated $20 million in primary health care services in various marginalized areas. Finally, the USG is investing natural resources management, economic growth, livelihoods, education, water and democracy and governance. Basic health services will continue to be an important complement to the many existing USAID programs and should exhibit approaches that will enhance this complementarity and promote synergy.

For more information on USAID/Sudan programs: http://www.usaid.gov/locations/sub-saharan_africa/countries/sudan/

D. Donor Funded Activities in Health

The World Bank-administered Multi-Donor Trust Fund (MDTF) has awarded contracts to one NGO per state to improve primary health care, referral hospitals, water, and sanitation for four of the ten Southern Sudan states. These funds will be matched by a one-third contribution from the GoSS/MoH.

The UN Children's Fund (UNICEF) is the primary source for vaccines and contributes significantly in strengthening health systems through training community-based health workers, developing behavior change messages, materials and health aids.

USAID collaborates with the World Health Organization (WHO) primarily on polio eradication and disease surveillance. WHO also provides TB and laboratory technical assistance to the MoH to strengthen capacity on epidemic preparedness and response. TB drugs for the national program are funded by Norway and the Global Fund for AIDS, Tuberculosis, and Malaria. Medecins Sans Frontieres (MSF) provides TB drugs in its target areas. The Global Fund has also recently approved a $72 million grant for the next five years to strengthen malaria services throughout Southern Sudan.

With USAID and WHO assistance, the MoH has successfully secured GAVI funding for health systems strengthening ($11 million). WHO has also worked with the MoH to secure GAVI funds to strengthen immunization services.

In the past several years, UNFPA has provided some contraceptives, reproductive health kits, and training in emergency obstetrics and fistula repair in selected sites in Southern Sudan. The next strategic plan (2008-2011) will focus on reproductive rights, population and development, gender equality. Through Population Services International, the United Kingdom provides social marketing of commodities and technical assistance.

The MoH has convened a "Roll Back Malaria" partnership with international partners to improve coordination. Also, the MoH has a developed joint malaria control program for FY 2008 and secured pledges from various donors to procure and distribute over 2 million insecticide treated nets in support of the World Malaria Day campaign.

The Carter Center collaborates with other implementing partners to eradicate Guinea worm, onchocerciasis, lymphatic filariasis, and trachoma from Southern Sudan. Organizations such as MSF-Holland, Medair, Malteser, and International Medical Corps work with the MoH to prevent and control visceral leishmaniasis (Kala-Azar) and trypanosomiasis (sleeping sickness).

V. USAID CROSS-CUTTING THEMES

As a key element of its support to the CPA process, USAID in Southern Sudan is strategically emphasizing a transition from relief to development in all program undertakings. Activities under this task order are expected to build on relief efforts and help to forge linkages and build capacities for government and civil society to move from immediate relief responses to more sustainable development efforts.

Another cross-cutting theme of the new health initiative is decentralization. The task order is expected to support the development of sub-national leadership to supervise, monitor, and assure the provision of quality primary health care services. The task order efforts would focus particularly at the SDP and county levels, although some continued assistance at the central and selected State levels may be indicated. The task order will complement World Bank-assisted MDTF efforts, which are more focused at the State and central levels. The task order will also reinforce USAID's democracy and governance initiatives and will increase transparency and accountability in the health sector while at the same time bringing government services closer to the people.

All activities under the task order are expected to address the cross-cutting theme of civil society capacity building by involving local community-based NGOs, CBOs and FBOs in service delivery, outreach, and demand generation. The project will also address rolling out national policies and guidelines; disseminating technical protocols; and improving capacity for supervision at the State and county levels. Modest support will continue to be provided at the central level to advocate for increased resources for the State and County Health Departments, and to deepen partnerships with NGOs – international as well as, and particularly, Sudanese, and civil society -- in the delivery of health services.

The Basic Package of Health Services includes provision for unsalaried community-level Home Health Promoters and for Village Health Committees to mobilize communities for preventative and appropriate presumptive primary care. Under earlier USAID efforts (SHTP1 and OFDA), many VHCs have been activated, with varying degrees of sustainable action. Activities under this task order are expected to focus particularly on the village level, applying "best practices" from Sudan and elsewhere to select, mobilize, supervise and support Home Health Promoters and to energize VHCs. In some counties VHCs and CBOs provide useful oversight and feedback on quality of care to service delivery points, which is essential to increasing utilization. The Contractor will be expected to apply "best practices" to assure Southern Sudan VHCs maximize their potential to assure quality health care to their communities.

Bringing health messages and services to groups that are all ready targeted for assistance provide opportunities to link the health activities with other USG activities in basic education, decentralized governance, food-for-peace, and livelihood activities. For example, linking health messages or services to food-for-peace distributions and/or development programs provides a unique opportunity to reach out to men and out of school youth, as well as women, outside of a clinic setting. Provision of food and nutrition support near or in health clinics, provide an incentive for women to enter the health system. Likewise, health messages that are behavior change focused and stress avoidance of high risk behaviors can be incorporated into curricula (print and radio) as part of USAID's basic education program, but might be adapted for out-of school youth and other high risk groups under this task order. USAID's Democracy and Governance program distributes radios throughout Southern Sudan which could serve as a focal point for listening groups (churches, women's groups, in- school, out-of-school, other) to absorb information about high impact services. Incorporating health messages into interactive radio is a way to extend health education beyond fixed SDPs and reinforce health-seeking behaviors.

Gender is an important consideration in this task order. Although data for Southern Sudan are scant, there is concern that years of war and displacement have increased the prevalence of gender-based violence. Attention will focus on the linkages between violence against women, maternal health, healthy pregnancy outcomes and HIV/AIDS. The Sudanese constitution has provision for a minimum of 25% women in public sector positions at all levels, e.g. all the way to the VHC. Partners will be encouraged to follow this provision in their implementation and to encourage women to step forward and participate in all project-supported fora. (See Sudan Gender-Based Violence Assessment on the website associated with this procurement).

The focus on gender must emphasize male involvement and male behaviors. Experience in other countries reveals that improving men's knowledge of family planning and reproductive health and the benefits of preventive care to both men and women are important considerations in improving the health of women. Experience also suggests that in some areas, men are engaging in much higher levels of risky behavior than women, warranting a focus on male behavior in order to reduce multiple partnerships (e.g. Uganda's "zero grazing" program) and reduce occurrence of high-risk sex. Linking HIV/AIDS to family planning information can be targeted to males to encourage faithfulness and to involve them in family planning decision making with their partners.

VI. DETAILED STATEMENT OF WORK

A. Objectives

SHTP2 will build on the decentralization of primary health service to improve the health status of the Southern Sudanese people. Specifically, USAID's health investment will strengthen county and community capacity to provide health services and improve health practices at the existing 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1. As stated in the Background section above, SHTP1 was designed and launched before the signing of the CPA. Its focus was necessarily establishment of the basic building blocks of a health system, including infrastructure rehabilitation, provision of basic equipment, training, and establishment of initial material and commodity supply systems. The second generation project – SHTP2--will accelerate progress along the relief-to-development continuum. The Contractor will have to carefully balance the quick provision of high impact services to meet growing expectations of returnees in particular, while at the same time increasing Sudanese ownership of health services and systems. The project is expected to enable CHDs to ensure high impact services are delivered and that health facilities and civil society groups take responsibility for health improvements and changing key health behaviors. In order to ensure these objectives are accomplished, the project will focus on the following results:

- Expanded access/availability of high impact services and practices;
- Increased Southern Sudanese capability to deliver and manage services; and
- Increased knowledge of and demand for services and healthy practices.

To achieve these objectives the program will include the following components: **1. Service Delivery and Community Mobilization; and 2. Health Systems Strengthening.** In the

following text, these objectives are described separately; however, this program will tightly integrate systems strengthening and service delivery into its approach.

B. Duration and Fund Sources

SHTP2 is expected to be implemented for a three-year period, from o/a January 2009 – December 2011.

The Contractor is expected to mobilize in Southern Sudan in the second quarter of the FY 2009. The initial activities under this solicitation will overlap and complement those of current prime Contractor. The Contractor is expected to build on the success of the SHTP1 2004-2009 project and to the extent practical, utilize the existing project infrastructure, equipment, vehicles and office space. Although the approved strategy period is 2009-2011, funding provided in 2009 is expected to fund activities through at least first quarter 2010. To the extent possible and pending the availability of funding, activities under this solicitation will continue in approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Note that the PEPFAR HIV/AIDS funding is sourced through the annual Country Operational Plan (COP) under the Office of the Global AIDS Coordinator in the Department of State, and conveys a separate set of budgeting and reporting requirements. The legislation for the second phase of PEPFAR (PEPFAR2) was just passed into law in late July 2008 as this solicitation was being prepared. It is possible that FY2009 and FY2010 categories and funding availability may differ.

All figures given are indicative and subject to the annual planning and budgeting process as well as Contractor performance.

Illustrative Funding Sources

The estimated range of this procurement is $42- 45 million over 3 years. The possible sources of USAID funding are listed below and the successful offeror will be required to track expenditures and results according to each funding source in providing an integrated package of high impact services in the focused counties. For budgeting purposes the range of first year activities should be between $9-10 million with years two and three receiving approximately equal treatment.

SHTP-2 Illustrative Budget

Program Funding Source	FY 2008 funds	FY 2009 funds	FY 2010 funds
PEPFAR/HIV/AIDS (See FY08 COP)	10%	9%	8%
3.1.1.1 PMTCT 3.1.1.2 Abstinence & Being Faithful 3.1.1.3 Other Prevention 3.1.1.14 Other Health Policy and Systems Strengthening			
Malaria	11%	17%	19%
3.1.3 Malaria 3.1.3.1 ACT treatment 3.1.3.2 LLITNS distribution 3.1.3.4 IPT treatment			
Child Survival/Maternal Health	67%	60%	59%
3.1.6.1 Birth Preparedness & Maternity Services 3.1.6.4 EPI Services 3.1.6.8 Water, Sanitation Hygiene			
Family Planning	11%	11%	11%
3.1.7.1. FP Services 3.1.7.4 FP Communications			
Water & Sanitation 3.1.8.1 Safe Water Access 3.1.8.2 Basic Sanitation	0%	3%	3%
Total	**100%**	**100%**	**100%**

C. "Lead Agencies" and Local NGOs/CBOs

Building on the SHTP1 model, and following GoSS/MoH and state MoH policies and practices, NGOs are responsible for delivering health services in Southern Sudan, in partnership with CHDs and state MoHs. The evolving practice is to have one NGO or "lead agency" in each county. . The successful Offeror will be required to ensure that the current implementing lead agencies are included as sub-contractors, and that the lead agencies will work with local NGOs, CBOs and FBOs to strengthen local capacity during the task order period.

Under the current SHTP 1, the lead agency partner NGOs operated under grant arrangements. The Basic IQC limits the US dollar amount US NGOs can receive as a "grant" under a task order. Therefore Offerors are expected to propose performance-based funding relationships

(subcontracts) with the "lead agency" in each focus county to achieve results described in this solicitation.

The Contractor is encouraged to consider use of performance incentives in their relationship with lead agencies, including such concepts as performance payment for achievement of particular coverage milestones e.g. percentage of children vaccinated, increase ANC visits by pregnant women, or for increases in per-capita service provision. Experience in other countries demonstrates that a robust monitoring and evaluation system is essential for any model of performance-based financing (PBF). Offerors shall describe how they would provide for verification of results in any proposed pilot or roll-out of a PBF plan.

An estimated 75% of annual funding is expected to be allocated to these sub-contracts.

The Contractor will be required to identify opportunities for working with non-health civil society groups such as, women's groups, parent/teacher associations, youth associations, religious groups, sporting associations, drama clubs, and dance troupes to expand advocacy and awareness for health services. The Contractor is strongly encouraged to create synergies with other USG funded local NGOs and CBOs in education, livelihoods, food security and governance to maximize impact. For budgetary purposes, an average annual amount of $400,000 per year should be included in the budget to offer quick dispersing mechanisms with micro grants ranging from $10,000-$25,000. Multi year grants to the same organizations are acceptable. This Grants Under Contract (GUC) mechanism will take advantage of funding targets of opportunities which respond to new opportunities for expanding high impact services among groups and in areas not identified at the writing of this TO.

D. Performance Requirements for Component One: Service Delivery and Community Mobilization

The project will focus on the provision of a package of high impact services and behavior change interventions that have the greatest impact on the burden of disease and health outcome in Southern Sudan. These high impact services/practices will focus on facility-based and community interventions. Both levels are critical for improving the health of the Southern Sudanese population through the following high impact interventions:

1) **Child Health** – Immunization (measles, DPT3, and polio), Acute Respiratory Infections (ARI) and Diarrheal Disease.
2) **Nutrition:** Exclusive breastfeeding, promotion of infant and young child feeding, twice yearly vitamin A supplementation
3) **Malaria:** Malaria control including use of long-lasting insecticide treated nets (LLITNs), intermittent preventive treatment (IPT) and prompt treatment with an effective anti-malarial.
4) **Hygiene and Sanitation Practices:** Household level water, sanitation, and hygiene**.**
5) **Maternal Health:** Ante-natal, safe delivery, and post-natal services
6) **Family Planning**: Child spacing and family planning information and services.
7) **Prevention of HIV/AIDS:** PMTCT and behavior change to delay sexual debut and reduce multiple risk behaviors.

The Contractor is responsible for tasks and results outlined in Results 1 – 7 below, over the period of performance 2009-2011. In addition the Contractor will be responsible for results under the systems strengthening component (Section E) described later in the TO.

1. Child Health

Summary: By the end of 2011, USAID expects that more than 50% of children under the age of one who reside in the communities covered by project-supported service delivery points will be fully immunized (measles, DPT, polio) and no less than 60% of project focus counties will be achieving greater than 80% DPT3 coverage. These targets are commensurate with GoSS expectations for 2012 in its recent GAVI proposal.

By 2011, USAID also expects that trained, motivated and supervised Home Health Providers will be treating an increasing share of child diarrhea and child ARI in project focus counties relative to those treated at PHCU/Cs.

USAID/Sudan will contribute to the Agency's program and goals for reducing Maternal and Child Mortality as outlined in the 2008 Report to Congress.

The Sudan Household Survey (SHHS) of 2006 found in the 10 Southern States that an average of about 24% among children aged 12-23 months received DPT3 vaccination at any time up to the date of the survey, which is less than half of the national Sudan average. In the Southern States, Central Equatoria (where Juba city is located) had the highest coverage, at 55%, followed by Upper Nile and United at about 36%, "… a figure at least twice as high as all the remaining Southern States that have reported a low coverage of less than 20%." (SHHS, p. 59).

The SHHS also reported that 42.9% of children under five had diarrhea in the two weeks preceding the survey, and only 22% of the children with diarrhea were managed competently at home. Similarly, 13.5% of children under five had suspected pneumonia in the two weeks preceding the survey; almost 90% of them were taken to a health care provider.

USAID Standard Indicators:

Number of children less than 12 months of age who received DPT3 in areas currently assisted with USAID funds. Source: USAID PMP, 2007	Actual 2007 7,907 Target. 2008 13,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
The percentage of children less than 12 months of age who received DPT3 in areas currently assisted with USAID funds. Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to	Actual 2007 16.4% Target. 2008 21.5% Target. 2009 40% Target. 2010 45% Target 2011 50%

FY 08 Appropriations pp.133-134	
Number of health personnel trained in immunization, diarrhea management and ARI management with USG support. Source: USAID PMP, 2007	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide

Description: This activity is implemented by the Contractor and project lead agencies in collaboration with WHO, UNICEF and the GoSS With the new GAVI proposal, the immunization system and immunization rates in Southern Sudan are expected to improve dramatically in the next four years, and USAID and its partners will be a key partner in this progress. There is a need to accompany this strengthened effort in immunization with a strengthened effort in community mobilization for immunization, as well as other key child health protocols in diarrhea and ARI.

The SHTP1 assessment records varying degrees of adherence with UNICEF and GoSS guidelines by the SHTP1 NGO partners, and varying results. The Contractor under this task order is expected to significantly increase adherence to guidelines and standards to so that there is a valid and measurable increase in vaccination of children in the focus counties. Past efforts have focused primarily on getting the supply-side moving; under this second-generation project, the supply-side must continue to be nurtured but much more attention needs to be given to generating demand. There is a particular need to mobilize Village Health Committees, other civil society organizations in the county, the County Health Departments, and Home Health Providers to assure that all children in the community receive all recommended life-saving vaccinations. Offerors should consider use of innovative approaches such as radio messaging and drama with church groups, women's groups, market settings, school-based child health programs, in- and out-of-school child-to-child health campaigns, and strengthened collaboration with CHDs.

SHTP1 has done a remarkable job at placing boreholes and latrines at most of the health facilities: in the first 6 counties, 93% of facilities have boreholes and 83% have latrines. This task order continues to emphasize clean water and sanitation and incorporate best practices funded elsewhere by USAID. Offerors may wish to consider the Madagascar Champion Communities model, with WASH-friendly facilities, schools and communities all promoting clean and safe water and sanitation. See USAID/Madagascar document in major annex section

The Contractor is also expected to increase skills and knowledge, particularly at the home and community level, of case management of diarrhea and ARI. The GoSS/MoH Basic Package of Health Services (BPHS) states that at a minimum, Home Health Promoters should be able to undertake information-education-communication (IEC) on these key health problems, as well as community-based social marketing of health products including *Water-Guard* (safe water solution). They are also to be engaged in active case finding and referral. The Contractor shall assure that the Home Health Promoters focus on: prevention of diarrhea point-of-use (typically household or school) water treatment to ensure the safety of drinking water; and provide health education messages on improvements in key hygiene behaviors, such as correct water handling and storage; effective hand washing; and safe feces disposal. The Contractor shall promote

home-based treatment with oral rehydration therapy (use of ORS, recommended home fluids, and/or increased fluids with continued feeding) to prevent severe dehydration, and treatment with zinc to reduce the severity and duration of diarrhea.

The BPHS also provides for Home Health Promoters in geographically very isolated areas to undertake an Integrated Essential Child Health Care approach that includes treatment and guidance for children with diarrhea, ARI and fever, with ORS/zinc, amoxicillin and ACT, respectively, and referral of sick children to PHCU/C. Dispensing of antibiotics at the community-level must be carefully introduced and managed, but holds great promise for increasing coverage in Southern Sudan.

USAID collaborates closely with the GoSS, state MoH, UNICEF and other donors and partners to increase immunization rates. Through other mechanisms, USAID provides annual funding to WHO as a contribution to polio eradication and will provide funding to the new USAID Global Health Bureau Maternal Child Health Integrated Project (MCHIP) to provide target TA. USAID will continue to collaborate with the MoH to ensure WHO, MCHIP, and other partners address the constraints faced in human resources (unclear roles, staff skills, management); the cold chain system and vaccines management; and monitoring and record keeping in order improve coverage. This combination of specialized resources will lead to better synergy of donor efforts, improve logistics and capacity at central, state and county levels to manage the EPI program and resuscitate routine immunizations.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to child survival interventions (immunization, prevention, and treatment of diarrhea diseases and acute respiratory infections) in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards. At a minimum:
a) Increase current vaccination rates for children < one years old in the SDPs in project focus counties to no less than 50% and increase numbers of children vaccinated at these sites.
b) Increase outreach and community level activities to expand the availability of growth monitoring, nutrition, sanitation, and health promotion services for infants and children.
c) Assure that target PHCCs and PHCUs are staffed with appropriately trained cadres and are providing a quality standard package of immunization, nutrition, and prevention/treatment of diarrhea and pneumonia.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with Home Health Promoters and TBAs to provide outreach programs in immunization, nutrition, and prevention/treatment of diarrhea and pneumonia in communities.

2. Nutrition

Summary: By 2011, USAID expects that the percentage of children under 5 years of age who received vitamin A in areas currently assisted with USAID funds will be no less than 70%. This target is commensurate with national GAVI targets.

By 2011, USAID also hopes to increase the percentage of children 0-5 months of age benefiting from exclusive breastfeeding from 21% (SHHS, 2006) to 50%, and to improve and increase counseling on the introduction of appropriate and timely weaning foods to children.

USAID expects to increase Vitamin A distribution to children between six months and five years of age and to broaden coverage of Vitamin A and other key nutrients to children and others. As stated in the SHTP1 assessment, current data for Vitamin A coverage are questionable because Vitamin A administered on National Immunization Days is not reported on the child health card. The Contractor will work with the state and CHD as well as other partners to incorporate Vitamin A supplementation into the routine service package. Finally, USAID expects to reduce the deaths resulting from diarrhea and pneumonia through health education activities and broader and more efficient distribution of preventive health care products.

USAID Standard Indicators

Number of children under 5 years of age who received vitamin A in areas currently assisted with USAID funds 2007, 2008 Source: USAID PMP	Actual 2007 43,263 Target. 2008 35,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
The percentage of children under 5 years of age who received vitamin A in the last six months in areas currently assisted with USAID funds 2007 Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual 2007 11.6% Target 2008 25% Target 2009 35% Target 2010 55% Target 2011 70%

Description: This activity will increase the delivery of nutrition services at health posts to children and pregnant women. These services include health education to women for preventing malnutrition, promoting exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition. Many of the SHTP1 partners found that provision of food for mothers and children provides a good incentive to increase ANC attendance; where possible, this practice is encouraged. Use of Home Health Promoters to provide IEC on the benefits of exclusive breastfeeding and to refer children needed supplemental feeding shall be stressed.

USAID closely coordinates with other entities involved in nutrition to reduce duplication of effort and compatibility and effectiveness of services delivered. Through another mechanism,

USAID will provide funding to the USAID Global Health Bureau nutrition activity FANTA2 (Food and Nutrition Technical Assistance) to provide more specialized technical assistance to the

GoSS in state-of-the art practices to provide Vitamin A supplementation to vulnerable populations. USAID does not intend to finance food under this project, but encourages the Contractor and its lead agencies to collaborate with agencies that do provide food aid for this purpose. The PL 480 Title II program expects to start Multi-Year Assistance Programs (MYAPs) in selected areas of Southern Sudan in late FY09, which would provide some complementarity with Contractor efforts under this component.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to Vitamin A, exclusive breastfeeding and promotion of infant and young child feeding in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) The percentage of children under 5 years of age who received vitamin A in areas assisted with USAID funds will be no less than 70%
b) The percentage of children 0-5 months of age benefiting from exclusive breastfeeding in areas assisted with USAID funds will be no less than 50%
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC and counseling on Vitamin A supplementation, exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in Vitamin A supplementation, exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition.

3. Malaria

Summary: By the end of 2011, USAID expects that 95% of USG-assisted health facilities in the focus counties will comply fully with GoSS and international clinical standards for case-management of malaria.

There is no baseline for the SHTP1 counties for these data, thus the Contractor will have to establish one. The assessment found uniformly high knowledge of treatment protocols among PHCC/U staff interviewed.

The SHHS of 2006 found that only 11.6% of households had at lead one ITN but that 21.97% of children under five years of age were sleeping under ITNs. It also found that 46.99% of children under five had received anti-malarial treatment in the two weeks prior to the survey, although less than 4% received the recommended artemisinin combination therapy (ACT).

Note that malaria in pregnancy is covered under maternal health below.

USAID Standard Indicators:

Assessment of USG-assisted clinic facilities' compliance with clinical standards	Actual 2007 No Data (ND) Target. 2008 25% Target. 2009 50% Target. 2010 75% Target 2011 95%
Number of ITNs distributed to USG-supported counties. (custom indicator) 2007, 2008 Source: USAID PMP	Actual 2007 19,374 Target. 2008 180,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Malaria Number of people trained in malaria treatment or prevention with USG funds	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide

Description: This activity is implemented by the Contractor and project lead agencies in collaboration with the GoSS, UNICEF, WHO, and GFATM partners implementing the Round 4 Malaria grant.

Much of Southern Sudan's malaria control efforts have focused on distribution of ITNs and LLITNs. To have high impact, the nets need to be distributed and their correct use ensured through practical demonstrations. Distribution of nets, demonstration of correct use, and home follow-up is an activity suited for Home Health Providers and VHCs. The SHTP1 assessment found that most PHCC/U staff correctly responded to questions about appropriate treatment and appeared to be following the national program guidance for the treatment of malaria. The GoSS/MoH is working with one lead agency on a small operations research program where Home Health Providers dispense ACT. The MoH is concerned with adequate supervision. Should the operations research effort so indicate, the expansion of Home Health Provider responsibilities, coupled with adequate supervision, should greatly help in case management of malaria.

The Contractor under this task order is expected to work closely with its sub-partners, PHCC/U staff, CHD, Village Health Committees, home health volunteers, local community groups, and others to mobilize communities to obtain and utilize LLITNs correctly, particularly for children under five and pregnant women. The Contractor is also expected to provide continued training to PHCC/U staff in new management regimes, and to collaborate closely with the CHD to establish improved supervision, quality assurance, and data gathering and reporting.

USAID is collaborating with a number of partners to assist the National Malaria Control Program. In FY06 USAID placed a long-term technical advisor in the Pharmaceutical Unit at

the MoH to improve the management and distribution of malaria treatment drugs, and provided assistance in the establishment of a logistics management system at the MoH. In FY08, in anticipation of improved logistic management systems, USAID will continue support to the advisor and supporting short-term TA and training, and will provide funding for procurement of first and second-line drugs for treatment of malaria.

These activities will complement the significant funding provided under the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). To date, Sudan has disbursed $37.8 million under Round 2 for Malaria, and has recently been approved for $72 million under Round 4. The GFATM funding will assure availability of LLITNs; the challenge for USAID partners will be to assure distribution and use by vulnerable populations. The Contractor will work with GoSS and GFATM to ensure LLITNs are provided to SHTP 2 for distribution to the 145 SDPs and others that may be added.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to malaria prevention and quality case management in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum:

a) Increase USG-assisted health facilities' compliance with clinical standards in the SDPs in project focus counties to at least 95% by 2011.
b) Increase outreach and community level activities to increase correct use of LLITNs with particular attention to children under 5 and pregnant women.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing correct case management of malaria.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in malaria prevention and case management.

4. Hygiene and Sanitation

Summary: By 2011, USAID expects the number of people in focus counties with access to improved drinking water supply as a result of USG assistance to increase to no less than 500,000 people (about 25% of the population of the focus counties).

The SHHS found that 48.3% of households in Southern Sudan use an improved source of drinking water. This varies widely, with Jonglei (22%), Western Equatoria (35%), Central Equatoria (37%) and Western Bahr el-Ghazal (37%) having particularly low rates. The primary source of water is a tubewell/borehole or an unprotected well.

USAID Standard Indicators

Number of people in target areas with access to improved drinking water as a result of USG assistance.	Actual 2007 30,000 Target. 2008 50,000 Target. 2009 75,000

Source: USAID PMP	Target. 2010 125,000 Target 2011 250,000

Description: The Contractor will collaborate with County Health Departments and UNICEF to assure that all service delivery points have functioning clean water supplies and sanitation facilities, including on-site hand washing facilities, latrines, and proper disposal for medical waste.

The Contractor shall assure that Home Health Promoters, Village Health Committees, and PHCC/U staff are well trained, motivated and supervised to provide IEC, counseling, and assistance to households and communities to improve water supply and sanitation. In some cases this will mean construction of a boreholes, and organization of a Water Management Committee to assure pump maintenance. In other cases this may involved well-capping; repair of existing boreholes and wells; and otherwise improving basic community water supply. In all cases the Contractor shall work closely with community groups to foster ownership of the water source so that improvements can be sustained over time.

The Contractor shall also introduce and/or expand technologies or products to assure household-level clean water. In collaboration with the GoSS/MoH, in 2006 Population Services International (PSI) in Sudan introduced WaterGuard, a chloroquine-based household water treatment tablet to ensure access to safe drinking water. The point-of-use tablet kills micro-organisms that cause diarrhea. WaterGuard is distributed and promoted through commercial retailers, CBOs, and health care facilities. The Contractor and lead partners are encouraged to collaborate with PSI to determine if some form of distribution – possibly through Home Health Promoters or VHCs – would be viable in the focus counties. The Contractor shall foster other means of protecting home-based water supply.

The activity should also promote improved community and individual hygiene and sanitation, with an emphasis on correct hand-washing; correct disposal of feces; and, in collaboration with VHCs, improved community sanitation and drainage. Where schools exist, the Contractor shall work with UNICEF and USAID's Education Office to assure that proper latrines are constructed and maintained. Use of innovative means of IEC/BCC, such as the Madagascar-model for "WASH-friendly health facilities, schools, and communities" or other in-school and out-of-school child-to-child health and/or peer educator programs, should be considered. The Contractor should build on USAID successful interactive radio program in the education sector to promote hygiene and sanitation messages throughout the focus counties.

USAID/Sudan received substantial earmarked Water and Sanitation funding in FY08 and expects to continue to receive similar levels in coming years. These funds are being provided to other partners through the "*Building Responsibility for the Delivery of Government Services (BRIDGE) Program*". A substantial amount may be focused in the Three Areas (outside of the SHTP1 target area). However, four SHTP1 current partners work in BRIDGE four southern states along the northern border: Warrap, Unity, Upper Nile, and Northern Bahr el-Ghazal. (for more information on BRIDGE, see www.grants.gov, Funding Opportunity Number M-OAA-GRO-LMA-08-715) In FY09 and FY10, it is expected that resources for Water and Sanitation

will increase and be available for SHTP2. Additionally, OFDA is providing modest continuing water and sanitation efforts in some areas. The Contractor is encouraged to identify synergies with water and sanitation efforts carried out by these other USG partners, and build on OFDA investments and best practice in Southern Sudan to reduce duplication of effort and to enhance compatibility and effectiveness of services delivered.

The overall strategy for USG-supported water-related activities was articulated in the *Paul Simon Water for the Poor Act of 2005: Report to Congress*, U.S. Department of State, June 2006. See annex or refer to http://www.state.gov/documents/organization/67716.pdf. Among the principal objectives is to increase access to, and effective use of, safe water and sanitation to improve human health. The Act requires annual reporting on USG efforts to implement the strategy, which includes USG support to help reach the Millennium Development Goal targets in increasing access to improved water supply and basic sanitation. The Contractor for this task order will be required to assist in reporting on any water funds received, as required by the Act.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to improved drinking water supply and sanitation facilities in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) The number of people in target areas with access to improved drinking water supply as a result of USG assistance (boreholes, WaterGuard, other) shall increase to at least 250,000.
b) The number of people in target areas with access to improved sanitation facilities as a result of USG assistance shall increase.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC/BCC on improved drinking water supply, hygiene, and sanitation.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in improved drinking water supply, hygiene, and sanitation

5. Maternal Health

Summary: By 2011, USAID anticipates that the basic package of prenatal, neonatal and post-partum care services are available at 50% of USG-assisted service delivery points in focus counties.

By 2011, the proportion of pregnant women who deliver in health facilities with a skilled birth attendant meeting minimal emergency obstetric and neo-natal care standards will increase to 20%. USAID/Sudan will contribute to the Agency's program and goals for reducing Maternal and Child Mortality as outlined in the 2008 Report to Congress.

USAID Standard Indicators

Number of deliveries with a trained TBA or MCH workers in USG assisted programs. Source: USAID PMP, 2007	Actual 2007 6,581 Target. 2008 12,000 Target. 2009 15,000 Target. 2010 20,000 Target 2011 30,000
Percentage of assisted deliveries by trained health service providers in USG supported counties 2007 Source: SHTP1 Assessment	Actual 2007 2.5% Target. 2008 3% Target. 2009 5% Target. 2010 10% Target 2011 15%
Number of women with a skilled attendant at birth Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual No Data Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Percent of women with a skilled attendant at birth Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Percentage of women with at least 1 ANC visit Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Percentage of women with at least 4 ANC visits. Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of women receiving a postpartum visit within 3 days of birth. Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide

08 Appropriations pp.133-134	
Percent of women receiving a postpartum visit within 3 days of birth. Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of mothers receiving iron folate Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Percent of mothers receiving iron folate Source: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations pp.133-134	Actual ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide

Description: The MoH/GoSS is just completing its Maternal, Neonatal and Reproductive Health Strategy and Action Plan for 2008-2012 which forms the basic guidance for this area of intervention. The Contractor will ensure that pre-natal care meets GoSS/MoH standards as established in existing protocols, and that all lead agencies assure that SDPs have adequate equipment (including delivery tables) and supplies (TT, iron and folic acid, STI detection materials, etc.) to meet national standards.

Post partum care is also an integral part of maternal health services. GoSS/MoH policy is moving away from TBAs and toward assistance by a trained Community Health Worker or Maternal and Reproductive Health Worker. A full description of new protocols is available in documents at the website associated with this procurement.

The key issues in maternal health can be summarized as follows:

- About 94% of births take place at home (UNICEF).
- Although about 77% of these deliveries are assisted by attendants, most of these are traditional birth attendants with little training.
- Antenatal care coverage is low and usually lacks tetanus toxoid immunization and other services.
- There is a near absence of family planning and child spacing information and services. Data collection systems are poor.
- TBAs are the key promoters of information on the importance of ANC attendance and safe deliveries to pregnant women and only link between health facilities and pregnant women.
- There is no access to Emergency Obstetric Care (EmOC).

The Contractor shall undertake a focused and intensive maternal health program in focus counties. Among activities to be considered are the following:

1. Assess the TBA population and select among them a cadre that can be upgraded. These upgraded cadres of TBA can be supervised by a select team of 5 to 6 midwives hired from outside Sudan on short contract basis. This team can begin to put systems in place.
2. Refocus the work of the remaining TBAs on health education (including child spacing and family planning) and recruitment for ANC attendance, in collaboration with Home Health Providers and VHCs.
3. Improve the logistics system to allow a regular supply of drugs to stock health facilities for maternal health, including all basic requirements for ANC, e.g. anti-tetanus toxoid).
4. Begin training and putting in place an *Essential* Obstetric Care package (as differentiated from an *Emergency* Obstetric Care Package, mentioned below) at facilities with appropriately trained personnel, promoting:

- Early registration (12-16 wks) for ANC
- At least 4 Antenatal Check-ups
- Prevention & Treatment of anemia
- Facility deliveries
- Postnatal Check-up

To handle obstetrical emergencies, the Contractor will collaborate with UNFPA to provide necessary training and equipment/materials comprising an Emergency Obstetrical Care Package at selected SDPs where staffs are adequately trained. In collaboration with GoSS, the Contractor may wish to consider piloting use of misoprostol at sites in selected counties where ANC coverage is high and/or there is a community health worker within an established program who can administer it correctly.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve maternal and reproductive health in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) The basic package of prenatal, maternal and neonatal and post-partum care services are available at 50% of USG-assisted service delivery points in focus counties.
b) The proportion of pregnant women who deliver in health facilities with a skilled birth attendant meeting minimal emergency obstetric and neo-natal care standards will increase to 15%.
c) The proportion of facilities in focus counties upgraded to mange safe delivery or basic emergency maternal and newborn care will increase to 20%.
d) The proportion of facilities in focus counties upgraded to mange maternal and newborn complications will increase to 20%.

e) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing improved maternal and reproductive health services.
f) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide improved maternal and reproductive health services.

6. Child Spacing/Family Planning

Summary: By 2011, 75% of SDPs in USAID focus counties will have a least four methods of contraception available (pill, condom, lactation amenorrhea method (LAM), and standard days method (SDM)) and staff will meet GoSS and international standards for FP counseling and provision of services. In selected sites where there are high rates of returnees, information and supplies for injectables will be piloted.

The SHHS found that among the Southern States the mean rate of contraception used in only 3.5% (any method), as compared with almost 8% for Sudan as a whole. In the south, the highest rate is in Central Equatoria (8%) followed by Northern Bahr el Ghazal, Eastern Equatoria and Upper Nile (roughly 5%).

There is no baseline for the SHTP1 counties for these data (SHHS data are valid only to the state level), thus the Contractor will have to establish one.

USAID Standard Indicators: Due to absence of data, baselines and targets are to be established by the Contractor in the first 60 days of the contract.

Percentage of women using a modern family planning method in areas currently assisted by USAID (Note: LAM is considered a modern method). 2006 Source: SHHS 2006 for Southern Sudan	Actual 2006: 3.5% Actual 2007: No Data Target 2008 No Data Target 2009 3.7% Target 2010 3.8% Target 2011 4%
Assessment of USG-assisted clinic facilities' compliance with clinical standards (in Sudan, must have at least 4 methods available)	Actual 2007 No Data Target 2008 baseline + 10% Target 2009 baseline + 30% Target 2010 baseline + 50% Target 2011 baseline + 75%
Couple years of protection (CYP) in USG-supported programs	Actual 2007 No Data Target 2008 No Data Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of counseling visits for FP/RH as a result of USG assistance	Actual 2007 No Data Target 2008 No Data Target 2009 Offeror to provide Target 2010 Offeror to provide

	Target 2011 Offeror to provide

Description: The SHHS data are difficult to disaggregate by state, but the text reports that the most popular method of contraception in Southern Sudan is lactation amenorrhea method (LAM), with insignificant figures for other methods of less than 1%. There is clearly a great deal of room for improvement to assure that families have the number of children they desire, when they desire them.

Child spacing is one of the key interventions to reduce maternal mortality, and as such requires increased attention at all SDPs and in community mobilization fora. Evidence shows that spacing children up to three years can reduce infant mortality by half. With the increase in returnees coming home after living in other countries, there is increasing demand for contraceptives from people who have actually used them. These individuals can also serve as informal "peer educators" will family and friends, to help them understand the health benefits of child spacing. By the end of 2008, the GoSS BCC Framework will be in place, so that materials and media can be developed for a more active child spacing/family planning campaign geared to protecting maternal health. Also, by the end of 2008, SHTP1 will have gained more experience in promoting child spacing activities in selected counties, so that some local experience will be gained.

The GoSS/MoH has also established a policy framework and family planning guidelines. USAID and UNFPA provide limited contraceptives, and the commodity logistics system getting more attention. More work is needed to increase knowledge and demand and to expand the method mix.

The SHTP1 assessment, at an annex, provides some detailed suggestions for a re-invigorated family planning program.

USAID is providing funding in FY08 for procurement of contraceptive commodities, through central mechanisms, and will initiate technical assistance to support the new Reproductive Health Directorate to roll-out child spacing/family planning as an essential component of reducing maternal mortality. USAID is also initiating funding to the central Global Health Bureau Leadership, Management and Sustainability Program to provide technical assistance and training to the central and state MoHs to increase advocacy for family planning and assist in development and dissemination of Southern Sudan family planning protocols and guidelines to address the unacceptable high rates of maternal death in Southern Sudan.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to child spacing/family planning IEC, counseling, and contraceptives in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum

a) At least four modern family planning methods (condoms, pills, LAM and SDM) are routinely available at least 80% of SDPs in project focus counties.
b) Injectables should be piloted into selected PHCCs in project focus counties with high rates of returns and/or urban areas/towns
c) Condoms available at 100% of service delivery points.
d) Family planning clinical standards are adopted and used in at least 80% of service delivery points.
e) Child spacing/family planning services and counseling become an integral part of HIV/AIDS testing services and PMTCT programs, where such exist.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC and counseling on child spacing/family planning.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in child spacing/family planning.

7. Prevention of HIV/AIDS

Summary: By 2011, USAID expects to integrate HIV/AIDS prevention activities into the 7 high impact services. This will include the provision of high quality prevention of mother to child transmission (PMTCT) services at selected SDPs in focused counties. This year will be the first year of PMTCT funding as a part of the high impact services. In addition, USAID also expects that the number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the project focus counties will increase to 200,000.

PEPFAR Standard Indicators: The Contractor will be expected to develop and provide targets for PMTCT as part of its Monitoring and Evaluation plan within 60 days of arrival in country.

Number of health workers training in the provision of PMTCT services according to national and international standards.	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of service outlets providing the minimum package of PMTCT services according to national and international standards.	Actual 2007 NA Target. 2008 NA Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of HIV-infected pregnant women	Actual 2007 N/A

who received antiretroviral prophylaxis for PMTCT in a PMTCT setting.	Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the project focus counties.	Actual 2007 N/A Target. 2008 N/A Target. 2009 50,000 Target. 2010 100,000 Target 2011 200,000
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB, above)	Actual 2007 N/A Target. 2008 N/A Target. 2009 5,000 Target. 2010 10,000 Target 2011 20,000

Description: Southern Sudan continues to experience high levels of population movement as conflict hotspots flare up and move away, and as an increasing number of returnees come back from neighboring countries to regain their homes and their livelihoods. Commercial and employment related travel has increased dramatically, and cities like Juba are virtually flooded with people from many parts of the world, including many Sudanese from the Diaspora. Concern also exists that demobilizing soldiers, some of whom may have been at higher risk during service away from their homes, may carry HIV to their places of origin. The turbulent social context is developing in a setting of low HIV awareness and substantial behavioral risks. The consensus view is that the epidemic is likely to accelerate unless aggressive prevention and care program are implemented and strengthened.

The USG has supported a range of HIV/AIDS prevention and care programs in Southern Sudan for several years under PEPFAR. Under SHTP2, FY08 funding will be provided for PMTCT, community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful (AB), and modest systems strengthening at the CHD. In FY09 and FY10, USAID expects to continue funding in these program areas and to provide funding in other prevention – including promotion of correct and consistent condom use – as well.

PMTCT is relatively new to Sudan but is an important aspect of providing pre-natal services to women. There are currently only 18 sites providing PMTCT services, mainly in Central Equatoria and some in Lakes state. Since there are 40 VCT sites in Sudan, and the MoH is rolling out provider-initiated testing and counseling (PITC), it is important to increase PMTCT service availability to maximize women's potential to protect themselves and their children. The Contractor is expected to assure that high quality PMTCT services will be at selected SDPs in SHTP2 counties that have HIV counseling and testing sites (as they are established), and that referral systems – including transport stipends to testing sites – are available for women who present with high-risk factors (e.g. STIs).

The Contractor will introduce PMTCT that meets national and USG guidelines (ref. www.pepfar.gov) in sites with reasonable access to VCT and/or PITC sites in the focus counties. The Contractor may also link with other USAID and CDC partners working in HIV and AIDS; where possible linkages with USAID cross-border initiatives and CBO and PLWHA networks shall be pursued.

Southern Sudan's abstinence and being faithful (AB) interventions target abstinence primarily on in-school youth and those youth who are not known to be sexually active. Efforts should be expanded to target church groups as a way to increase awareness among non-sexually active youth. The partner reduction (being faithful) efforts are linked to couples centered counseling and testing for other target groups, including military personnel and their families, truck drivers and their associates, and all couples who do not know their HIV status. The USG and other donors support aggressive mass media campaigns, including radio, billboards, TV and digital recording devices.

The Contractor for this TO is expected to take existing USG and other donor activities into account and to propose an AB effort for the focus counties that is well-integrated with other activities. This could include, for example, integrating AB counseling into pre- and post-natal counseling and PMTCT (where provided); assuring that schools and youth groups in the focus counties have Anti-AIDS Clubs or other AIDS awareness activities, and appropriate posters and media to promote abstinence; and community outreach through Home Health Promoters and peer educators to out-of-school youth and populations at risk, particularly mobile men. Both VHCs and CHDs should be considered key partners in this prevention effort.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to provide community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP-1. The Contractor will selectively initiate PMTCT services in counties where there is a reasonable volume of ANC clients and reasonable access to VCT or PITC.

Performance Standards: At a minimum
a) Home Health Promoters in higher-risk areas (e.g. near borders or military camps; with large markets; along transport routes) will be trained and have IEC/BCC materials to promote abstinence and being faithful particularly focused at youth.
b) Civil society groups and clubs (e.g. churches, sports clubs, and drama groups) will be trained to provide peer education in abstinence and being faithful at population meeting spots (sports events, dances).
c) High quality prevention of mother to child transmission (PMTCT) services will be available at all SDPs in selected counties that have HIV counseling and testing sites, and that referral systems – including transport stipends to testing sites – are available for women who present with high-risk factors (e.g. STIs).

d) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing community outreach that promotes HIV/AIDS prevention through PMTCT, abstinence and/or being faithful.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to community outreach that promotes HIV/AIDS prevention through PMTCT, abstinence and/or being faithful.

E. PERFORMANCE REQUIREMENTS FOR COMPONENT TWO: HEALTH SYSTEMS STRENGTHENING

USAID Standard Indicators:

OPHT Number of policies drafted with USG support 2007, 2008 Source: USAID PMP	Actual 2007 4 Target. 2008 4 Target. 2009 1 Target. 2010 1 Target 2011 1
Number of health personnel trained with USG support 2007, 2008 Source: USAID PMP	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of CHWs/HHPs trained and functioning (Agency definition to be finalized) See discussion: Working Toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY 08 Appropriations, p.9 column 2 of	Actual 2007 ND Target. 2008 ND Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	Actual 2007 NA Target. 2008 NA Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of people covered by USG-	Actual 2007 No Data

supported health financing arrangements	Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs	Actual 2007 No Data Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of improvements to laws, policies, regulations, or guidelines	Actual 2007 No Data Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of USG-assisted service delivery points implementing quality assurance/quality improvement (QA/QI) approaches	Actual 2007 No Data Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide

1. Health Systems Management

Over the last 50 years, relief organizations have been the main providers of health services in Southern Sudan. As Southern Sudan transitions from a relief to development environment, it is essential that the GoSS has the capacity to develop strong national policy, manage the health sector, and have strong civil society participation. While health services will likely be delivered by NGOs in the near term, the GoSS must have the capacity to plan, supervise, and manage the sector as a whole. Thus, principle objective of USAID/Sudan's involvement in health systems strengthening is to ensure that the GoSS at the county and state level are able to manage the delivery of high-priority health services. While sub-partners will be the closest to local governments, it is essential that the Contractor develop an assessment-based approach to strategically identify areas of system strengthening in each county and offer lead NGOs and their local government counterparts tools and strategies for effective management. To ensure close cooperation and collaboration, the successful bidder will co-locate with the GoSS Ministry of Health, SMOH and county health departments, to the maximum extent possible. This will promote capacity building and systems strengthen in order to sustain activities when USAID assistance decreases.

Performance Standard, at a minimum, in USAID focus counties:

a) 50% of County health departments are able to effectively produce strategic plans based on reliable health information

b) 80% of County health departments conduct routine monitoring and supervision visits to health facilities jointly with lead NGOs

c) 50% County health departments can effectively produce and defend county health budgets

d) 80% County health departments can effectively conduct aggregate forecasts of pharmaceutical and commodities, and are directly linked to all available supply chain channels
e) Contractor has identified and budgeted plan to co-locate in MOH and county health department premises

2. Health Sector Governance

Fundamental to the successful transition from a relief to development environment is the development of strong governance channels. It is essential that scare government resources are allocated in a cost-effective manner. These allocation decisions must be open to public participation and public scrutiny. The strengthening of civil society groups is fundamental to improving the responsiveness of service providers and government. A strong system of checks-and-balances must be in place to ensure the integrity of scarce resources.

Performance Standard, at a minimum, in USAID focus counties:
a) 80% of health facilities have an actively-engaged, well-functioning Village Health Committee that is involved in resource allocation, priority-setting, and dispute resolution.
b) Community groups, such as women's groups, youth groups, and church groups are involved in priority-setting and health promotion activities in at least 80% of focus counties.
c) 80% of County Health Departments hold meetings or other public fora (e.g. radio programs) to disseminate annual County plans and budgets.

3. Health Policy Dissemination/Roll-Out

With SHTP1 and other USAID and donor assistance, the GoSS has made impressive progress in improving health services and developing systems to support them. This work has included formulation, consensus-building, and issuance of a large number of policies and protocols. There is now backlog of need to disseminate and/or roll-out the policies and protocols, both to health personnel as well as key State and county government official and interested civil society organizations.

Performance Standard. At a minimum, in USAID focus counties:
a) All basic policies and guidelines rolled out in focus counties through a variety of ways including radio, town hall meeting, training, etc. as appropriate to target audiences.
b) 100% of CHDs and SDPs in focus counties have copies of key MoH policies, strategies, and protocols.

4. Human Resource Capacity

The capacity of human resources is the greatest challenge in Southern Sudan. To strengthen the human resources ability to provide quality health services, SHTP2 will focus primarily at the county and community levels through a "continuous engagement" strategy that includes formal and on-the-job training via supportive supervision. The Contractor will, as necessary, collaborate with MDTF lead agencies placed at the State level to improve States' capacities to strategically plan for county/community services. Additionally, the Contractor will work with

the national level to ensure standard training, curricula and program lessons are transferred to other States/counties and communities for broader impact. At the primary health care level, CHWs, MCHWs, TBAs, nurses, medical assistants, traditional healers and Home Health Promoters will be the capacity building focus. At the County and State levels, health personnel capacity will be strengthened to plan and ensure effective delivery of health care services.

Under SHTP1 USAID funded rehabilitation of five Regional Training Centers (RTCs) for health workers in Hakim (Nuba Mountains), Adol (East Rumbek), Maridi (Maridi), Yei (Yei), and Ganyiel (Panyijar). The GoSS is encouraged to support another five RTCs in the remaining five states. The Contractor will provide technical assistance to support this process, as requested by GoSS/MOH.

Under field support to USAID's centrally funded Capacity Project, separate technical assistance is targeted to supporting the government to develop and strengthen human capacity in the health sector. In the initial years assistance was targeted to the central level. During the implementation of activities under this TO, more the Capacity Project will support strengthening skills in management and monitoring of primary health care services at the state MoHs and county health department. Activities under this TO will compliment the government's efforts as it to rolls out capacity building at the state and county levels.

Performance Standard:

a) No less than 5 CHW/MCHW Training Institutes providing quality pre- and in-service training for focus county personnel.
b) Standard curriculum developed for Home Health Promoters utilized in focus counties
c) 80% of CHWs, MCHWs and HHPs, CHD and program staff trained and providing the package of high impact services at facilities and community levels.
d) Village Health Committees trained and providing feedback and oversight to at least 80% of health facilities and CHDs.
e) 50% of CHDs able to strategize plan and collaborate with State and communities levels on health care delivery.

5. **Gender**

In order for sustainable and equitable health outcomes to be achieved, the different needs of men, women, adolescents, and communities must be considered. In order to eliminate gender disparities, both women and men must actively participate in health-related decision-making. Effectively taking into consideration the impact of gender on health care choices will be important to achieving results under this task order. Household health related behaviors, spending levels on health care, choices related to family planning, and decisions related to participation in new, voluntary systems of primary health care are all heavily influenced by the pattern of gender relationships governing use of household labor and income, as well as by local cultural and social norms. In addition, attention to gender based violence and interventions to reduce/mitigate such violence should be addressed in each proposal. Attention should be given to build linkages integrating family planning and HIV/AIDS programming, gender based violence and reaching men in changing their behavior to reduce disease transmission and

increase their participation in protecting women's reproductive health. Each applicant must describe in its proposal how it anticipates dealing with gender issues as an integrated part of its activities, how the different needs and roles of men and women will be address and how the proposed approaches will foster the empowerment of women and men. Therefore, the bidder should include the following elements in addressing gender in their proposal

- Describe how interventions will address gender and increase male involvement in addressing high maternal mortality
- Ensure opportunity for equitable participation in County Health Department management, Village Health Committees and Water& Sanitation activities in programs by both women and men.
- Incorporate gender-equity targets for participation and benefit into activities.
- Ensure Monitoring & Evaluation Plan for collecting ante-natal data, family planning and HIV/AIDS data is gender-disaggregated data to track beneficiaries.

VII. QUALITY ASSURANCE PLAN

A variety of mechanisms will be used to monitor the progress/success of the activity and the Contractor's performance:

1. Monthly meetings with the CTO.
2. Review of Contractor's scheduled reports.
3. Feedback from GoSS, MoH, NGO counterparts and collaborating donors.
4. Site visits/TDYs by USAID personnel.
5. Meetings to review and evaluate work plans, annual and semi-annual progress reports.
6. Periodic impact assessments or performance evaluations.

The CTO will conduct periodic performance reviews to monitor the progress of work and the achievement of required results under this contract. These reviews will form the basis of the Contractor's permanent performance record with regard to this contract

VIII. WORK PLAN

The Work Plan/Performance Milestone Plan (PMP) is the key document for contract performance against which Contractor performance shall be monitored and evaluated by both USAID and the Contractor. The Contractor will propose the Work Plan/PMP as part of the technical proposal, and the final format will be agreed on during negotiation. During contract performance, the Work Plan will be up dated as required, subject to CTO approval. Contracting Officer approval of Work Plan updates shall be required if the proposed changes impact on the use of available contract funds. It is anticipated that USAID, GoSS, and key personnel will form a "Core Group Management Committee" to provide oversight during project implementation; review progress; and recommend changes. Such comments and changes, however, if accepted by the Contractor, shall not constitute a change from the terms of this contract. Annual Work Plans shall specify a time table for the implementation of planned activities and a summary program budget (by result category). The updates shall include a brief summary report on

contract performance to date. The Work Plan is intended to be a working document for the use of the Contractor and USAID. Annual updates to the work plan will be discussed with USAID and adjusted accordingly. Much of the information may be presented in tabular format, and there is no expectation of widespread public dissemination.

The Work Plan should include, at a minimum:

- Proposed accomplishments and expected progress toward achieving the results and performance measures tied to the Monitoring and Evaluation Plan (M&E).
- A time line for implementation of the years proposed activities.
- Information on how activities will be implemented.
- Major equipment to be procured.
- Details of collaboration with MoH (central and department) and other USAID-funded partners

IX. MONITORING AND EVALUATION PLAN

The Contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) Plan, which includes the relevant indicators found in USAID/Sudan's Performance Monitoring Plan (PMP) and the results indicated in each component area in this TO. The Contractor will propose the Work Plan/PMP as part of the technical proposal, and the final format will be agreed on during negotiation. Special attention should be paid to recommendations from the SHTP1 Assessment. Expected program results with illustrative indicators, mid-term benchmarks, end of project results provided partially in this document, should be further elaborated in the M&E plan. The M&E plan should be submitted to the USAID CTO within 60 days of the award of the contract. To the extent possible, the M&E plan will be integrated into, and enhance, existing MoH management systems. The M&E plan will be updated and revised as appropriate in collaboration with USAID.

The successful bidder will be required to submit a branding and marking plan in accordance with the USAID Automated Directive System (ADS) 320 within 60 days of signing the award. See http://www.usaid.gov/policy/ads/300/320.pdf for details with particular attention to contracts.

X. REPORTS

All work under this contract shall be completed by December 31, 2011. During the length of the contract the following reports are due in English according to the following schedule:

Type of Report	Date Due	Distribution
Annual Work Plan and Budget	60 days after signing of the award and a month before the ending of the current work plan during the life of the project.	3 copies CTO, CO, Task Order CTO
Monitoring and Evaluation	60 days after signing of the award	2 copies CTO, Task Order

Plan		CTO
Branding and Marking Plan	60 days after signing of the award	2 copies-CTO, Task Order CTO
Financial Quarterly Reports	SF 296 30 days after end of the reporting period	3 copies CTO, FM/USAID Sudan, Task Order CTO
Monthly Meeting with minutes	During the first week of the month	1 copy CTO 1 week after meeting
Performance Monitoring Reports	Quarterly for the first year and semi-annually thereafter; (October 31 and April 30), to coincide with the USAID annual reporting cycle; dates and format TBD within the first 30 days of the award	1 copy to CTO
Equipment Plan	Annually (as part of the work plan)	CTO, CO
Foreign Tax Reporting	April, for the preceding year	2 copies CTO, FM
Final Financial Report	90 days after completion of contract	4 copies CTO, CO, Task Order CTO and CDIE
Final Performance Monitoring Report	90 days after completion of the contract; first draft is due 30 days after completion of the contract	Same as above
Success Stories (format will be provided)	Minimum of one per month with photographs	1 copy to CTO

N.B. Workshop/Conferences/Training reports will be included in the semi-annual reports.

- The Monthly Meeting: The Contractor will meet on a monthly basis with the CTO and provide monthly summarized implementation and financial reports (NTE 5 pages) to the CTO.

- Quarterly GoSS/USAID/Contractor Core Group Meeting with minutes circulated back to group with action points now later than 5 working days.

- Quarterly Financial Report: The quarterly financial report should contain at a minimum:

  1) Total funds committed to date by USAID into the contract.
  2) Total funds expended by the Contractor to date.
  3) Pipe-line (committed funds-expended funds).
  4) Funds and time remaining in the contract.

- Semi-annual Performance Reports: every six calendar months, for the periods of April – September and October –March, to be provided within 30 days of the end of each period. At a minimum, semi-annual reports shall describe: current progress to date relative to the goals and objectives of the procurement's activities, achievement

of results, performance of requirements, and progress on result indicators within this procurement (Results 1, 2, 3, 4, and 5), beneficiaries disaggregated by gender; identification of problems or delays; a proposal to remedy these problems or delays.

- Success Stories: Once a month the Contractor will be required to submit success stories concerning the people level impact of their activities. These success stories should be accompanied by photographs of the activities described.

SECTION B – INSTRUCTIONS PREPARATION OF THE PROPOSAL

B.1. PREPARATION OF THE PROPOSAL

1. USAID will entertain proposals only from the entities under the first tier, TASC3-Global Health.

2. Applicants should submit a Technical Proposal of no more than 50 pages (page limit does not include resumes, graphs, or past performance information) directly responsive to the terms, conditions, specifications and clauses of this RFTOP. Technical Proposals should be single spaced, have a font size of Times New Roman 12 and have one inch margins.

3. All materials submitted must be in English. The Technical Proposal should address project components and results to be achieved under each component. The Technical Proposal must not make reference to *specific* costs or *detailed* pricing data in order that the technical evaluation may be made strictly on the basis of technical merit. USAID accepts no responsibility for errors or omissions in the documents. It is the responsibility of the offeror to ensure all proposal submissions have been received by the date and time deadline.

In summary the Receipt of Proposal Deadlines are as follows:

Hard Copy Submission Only: November 21, 2008 5:00 PM Nairobi, Kenya local time.

The following hard copies shall be sent: One (1) original plus Five (5) hard copies of a Technical Proposal, and one (1) original plus Five (5) hard copies of the Cost/Business Proposal should be submitted. Hard copies should be received no later than November, 21, 2008 at the address below:

4. All hard copies of the Technical and Cost/Business Proposals must be separated and placed in sealed envelopes clearly marked on the outside with the following words **"RFTOP No. 650-09-313 "Sudan Health Transformation Project Phase 2 Technical" and "Cost/Business Proposal"** as appropriate. These individual envelopes must then be bundled together to be received as one complete package. Hard copies should be submitted with the name and address of the offeror on the envelope and addressed to.

RFTOP 650-09-313
Marcus Johnson
USAID/East Africa
C/O American Embassy
United Nations Avenue, Gigiri,
Nairobi, Kenya

Proposals that are submitted late will be treated according to FAR clause 52.215-1(3). Proposals that are incomplete or are non-responsive may not be considered. Faxed Proposals are not authorized for this RFTOP and will not be accepted

B.2 INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL

A suggested format for the Technical Proposal is:

1. Cover Page -Title, name of organization(s) submitting proposal, contact person, telephone and fax numbers, address, and e-mail.

2. Executive Summary (not to exceed two pages) - Briefly describe the proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed.

3. Body of the Technical Proposal (not to exceed 50 pages) - Succinctly describe the proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed. The Proposal's structure should reflect the evaluation criteria listed in Section C. Pages exceeding the 50 page limit will not be read or evaluated. Offerors shall not include proposal material by referencing the annexes in an attempt to circumvent the 50 page limit.

4. Qualifications of Proposed Key Personnel not to exceed five positions (maximum three page CV s per position) – Briefly describe the technical background and qualifications of the proposed Key Personnel, using the criteria articulated below:

a) Academic and technical background and qualifications (including English) language ability) relevant to this Statement of Work;

b) Successful experience in providing technical assistance in developing countries and in areas relevant to this Statement of Work; and

c) Demonstrated interpersonal skills and managerial/technical abilities.

For all proposed long-term consultants, expatriate and locally-recruited, full resumes must be provided, presenting their experience in chronological order and listing addresses and telephone numbers of the last three immediate supervisors.

5. Corporate Capability (not to exceed three pages) The offeror will briefly describe the corporate capability of the firm using the criteria established below:

a) Qualifications and experience of the Offeror in carrying out activities and programs similar to those described in Section A;

b) Qualifications and experience of the Offeror in supporting and back-stopping long and short-term professional personnel on overseas assignments in developing countries; and

c) Qualifications and experience of the Offeror in managing several sub-contractors and/or sub-grantees to implement activities similar to the ones planned under this solicitation.

d) The Offeror is required to submit information on contracts, subcontracts, cooperative agreements, or grants performed over the previous three years that are similar in scope to the

work covered by Section A. The information supplied must include the name and address of the organization for which services were performed, a description of the work performed, the duration of the work and size (in dollars) of the contracts, subcontracts, cooperative agreements or grants, and the current telephone number of the responsible technical representative of the organization. USAID may use this information to contact technical representatives on prior contracts, subcontracts, cooperative agreements or grants to obtain information on performance. If the Offeror encountered problems in carrying out any of these contracts, etc., it should provide an explanation of the problem encountered and describe any corrective action taken.

6. Past performance will be evaluated as a means of predicting how the Offeror will likely perform. The following considerations will be examined:

a) Quality of Services: How well the Offeror complied with Task Order requirements;

b) Timeliness of Performance: How well the Offeror adhered to Task Order schedules and its responsiveness to technical direction;

c) Business Practices and Customer Satisfaction: How well the Offeror worked with the Task Order Contracting Officer (TOCO) and his or her technical representative(s). Customer satisfaction also measures the interface with the ultimate end-user of the services;

d) Key Personnel: How well the principal individuals elected performed in carrying out the activities called for under the contracts, subcontracts, cooperative agreements or grants; and

e) Cost Control: Whether the Offeror operated at or below budget, submitted reasonable price change proposals and provided current, accurate and complete billings.

7. Page Limit

The above page limitations of the body of the proposal exclude the cover page, the executive summary, the authorized attachments, resumes and the statement of corporate capability and past performance. Applicants should retain for their records one copy of the Proposal and all enclosures that accompany their Proposal. Erasures or other changes must be initialed by the person signing the Proposal.

The authorized attachments specified below shall not be counted towards the technical proposal page limit; however, any attachments other than those specified below shall not be read, and pages exceeding the Not to Exceed (NTE) notations listed will not be reviewed.

Authorized attachments:

- Staffing Plan (NTE 3 pages)
- Organizational charts with Position Descriptions (NTE 2 pages)

- Description of management systems and procedures required for successful contract administration (NTE 3 pages)
- Corporate capability statements (NTE 3 Pages)
- Resumes or curriculum vitae of Key Personnel (NTE 3 pages per proposed individual)
- Offeror NIH CPS Past Performance Reports (NTE 5 pages per report)
- Draft first year work plan (in table format) (NTE 2 pages)
- Transition/ 60 day start-up plan (in table format) (NTE 2 pages)

B.3 INSTRUCTIONS FOR PREPARATION OF THE COST/BUSINESS PROPOSAL

1. Cost/Business Management Proposal

a) This will be a three year task order with an estimated dollar value of $42-45 Million over the life of the Task Order. This range is provided to give offerors the relative order of magnitude of the anticipated project and should not be used as a target. Each offer will be evaluated for cost reasonableness and realism. The contractor will not be paid any sum in excess of the Task Order ceiling price or current obligated amount. The offeror is expected to propose a realistic budget to support the expected results described in Section A of this RFTOP. Offerors are reminded that the resulting Task Order will be partially funded through the various USAID funding sources and it is expected that the Successful Offeror will report expenditures and results achieved according to these funding sources.

b) The cost proposal should include a detailed budget for the three year period including explanatory notes. All schedules necessary to support and explain proposed costs with breakdowns on direct labor, fringe benefits, supplies and equipment, travel and per diem amounts, including international travel should be identified separately and broken down by destination, number of trips, and number of travelers. Include other direct costs, and indirect costs; personnel costs, allowances and benefits, such as costs associated with resident and short-term personnel; travel and transportation costs, including airfares (destinations and number of trips), per diems amounts, taxis, and car rentals; rent, equipment, supplies, domestic, and international communications; and indirect costs supported with a Negotiated Indirect Cost Rate Agreement (NICRA) from the cognizant Federal agency subject to Section B6 and B7 of the Basic IQC.

c) The bidder will demonstrate how they will leverage other non USG resources in order and attract new sources of funding to the health sector in Southern Sudan. While it is not a requirement, bidders are encouraged to identify how they may bring in addition funding and innovation in implementing activities under this task order.

Example Summary Cost Elements Total

001. DIRECT LABOR	$_____
002. TRAVEL, TRANSPORTATION & PER DIEM	$_____
003. ALLOWANCES	$_____
004. EQUIPMENT	$_____
005. SUBCONTRACTS	$_____
006. OTHER DIRECT COSTS	$_____
007. PARTICIPANT TRAINING	$_____
008. GRANTS UNDER CONTRACT	$_____
009. INDIRECT COSTS	$_____
010. FIXED FEE	$_____
TOTAL ESTIMATED COST PLUS FIXED FEE	$_____

Note: Individual subcontractors shall include the same cost element breakdowns in their budgets as applicable.

The offeror's budget present should include the following information:

001) DIRECT LABOR

A detailed level of effort estimate. Please provide a separate line item for each proposed position and identify each by name if known.

Biographical Data Sheets (AID Form 1420-17) supporting unburdened rates for proposed **Key Personnel** candidates.

Home Office Direct Labor and Related Fringe Benefits

The offeror shall provide the computations that were utilized in developing the proposed locally-hired national personnel and other non-U.S. expatriate salary.

The offeror shall show the unburdened rate and any other costs applied to develop the proposed salary.

Proposed Fringe Benefits and the calculation basis for the same.

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002) TRAVEL, TRANSPORTATION and PER DIEM

Estimated travel and transportation costs shall be in accordance with the clause of the Contract entitled "Travel and Transportation" (AIDAR 752.7002). The proposal for each Task Order shall specify, for each traveler, the itinerary (in terms of locations, and, if possible, dates), the estimated air fares, any transportation (i.e., excess baggage) cost [to include the weights, mode of transportation (air, vessel), and unit prices], and the subtotal of all travel and transportation costs.

Estimated per diem shall be in accordance with the most recent Department of State Maximum Travel Per Diem Allowances for Foreign Areas and prescribed Maximum Per Diem Rates for CONUS.

The breakdown of per diem costs shall be tied to the travel itinerary and work-days, and shall specify, for each traveler, location(s), number of days in each location, the per diem rate for each location, and the subtotal for all per diem costs. The proposal for each Task Order shall also include the total travel, transportation, and per diem costs.

003) OVERSEAS ALLOWANCES

Overseas allowances (other than per diem), if any, shall be in accordance with the clause of this Contract entitled "Differentials and Allowances" (AIDAR 752.7028) and the Standardized Regulations, and shall include, for each individual for whom the allowance will apply, the type of allowance, the calculation of the allowance, and the total overseas allowances costs.

004) EQUIPMENT

USAID will provide a majority of equipment, now being utilized under the current cooperative agreement, as government-furnished property, so any equipment costs shall minimal.

. 005) SUBCONTRACTS

Subcontracting is contemplated with other than the approved subcontractors identified in Section H.21 of the basic award, the offeror shall indicate the types of work to be subcontracted, stating: The percentage of each type of work subcontracted, the extent to which competition was or will be solicited prior to selection, subcontractor(s) selected and reasons therefore, and the method of analyzing prospective subcontractor proposals.

006) OTHER DIRECT COSTS (ODCs)

ODCs may include, but are not limited to, passports and visas, medical examinations and inoculations, communications, etc., shall be specified in terms of the number of units, the estimated unit cost, and total cost.

007) PARTICIPANT TRAINING

Participant training costs, if any, shall be in accordance with ADS 253 (Automated Directives System).

008) GRANTS UNDER CONTRACT

A plug figure of $400,000 per year for the 3 year task order is suggested where multiple grants to local organizations are anticipated.

009) INDIRECT COSTS

In accordance with the Offerors current NICRA and subject to the terms and conditions of Section B6 and B7 of the Basic IQC.

010) FIXED FEE

Negotiated subject to the terms and conditions of Section B8 Ceiling on Fixed Fee, of the Basic IQC.

B.4 REQUIRED CERTIFICATIONS AND OTHER INFORMATION

N/A

B.5 UNNECESSARILY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective Proposal in response to this RFTOP are not desired and may be construed as an indication of the applicant's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

B.6 AUTHORITY TO OBLIGATE THE GOVERNMENT

The TOCO is the only individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the proposal may be incurred before receipt of either a Contract signed by the TOCO or a specific, written authorization from the Task Order Contracting Officer.

SECTION C – EVALUATION CRITERIA

Each proposal will be scored by the technical evaluation committee using the criteria shown in this section.

I. TECHNICAL PROPOSAL *(100 Points)*

A. Proposed Technical Approach: Methodology and Content ***(50 points)***
The evaluation of the offeror's technical approach will focus on the following:

- The proposal expresses a clear understanding of the purpose of the activity **(5 points)**
- The proposal reflects a clear understanding of the development context in Sudan, including intercultural and gender issues as related to health sector activities **(5 points)**
- The description of how the Scope of Work will be accomplished is clear, practical, and results-oriented, and it adequately addresses all of the technical requirements specified by USAID/Sudan in the SOW. Proposals with activities that reflect realistic, imaginative and innovative approaches to achieving the objectives are encouraged in addition to addressing gender. **(30 points)**
- The proposed work plan and timeline clearly describe how the activities will be conducted. **(10 points)**

B. Proposed Experience and Qualifications of Key Personnel ***(40 points)***

Key Personnel (*40 points)* The Key Personnel listed below are suggested, offerors are free to propose Key Personnel up to five (5) positions

Chief of Party (COP)

The proposed Chief of Party is expected be responsible for the overall planning, implementation and management of the project and to establish the administrative framework to monitor and assure progress toward the achievement of the goals and objectives of the project. The incumbent is expected to:

- Have a minimum of a Masters Degree in Public Health or related area. Exceptional relevant experience may be considered in lieu of an advanced degree.
- Provide vision and strategic leadership.
- Have 10 years experience in the field of primary health care with an emphasis managing a team of highly successful performers.
- Have at least 5 years experience in managing donor funded projects and in the design and implementation of overseas health projects; preferably in East Africa or the Horn of Africa.
- Have the ability to perform at a senior policy level, demonstrated by previous experience in leading the development and implementation of international primary health care programs.
- Have the ability to manage a team, foster team work and to work as a team member.

- Liaise with senior GOSS and MOH officials, USAID officials, university professors and dignitaries, executives of NGOs, FBOs, CBOs, the for-profit business community, and senior members of the donor community in Southern Sudan.
- Ensure timely and communication with, and reporting to, the USAID/Sudan Cognizant Technical Officer.
- Have strong oral and written communication and presentation skills in English.
- Have strong computer skills (word processing, graphic programs and excel spread sheets).
- Be familiar with USAID or other USG administrative, management and reporting procedures and systems.

Technical Director/Deputy Chief of Party

The proposed Technical Director/Deputy Chief of Party is expected to be responsible for the overall technical direction of the project and to have at a minimum:

- A medical degree or Doctorate in Public Health.
- 10 years experience in the field of primary health care with in-depth technical knowledge of implementing maternal and child health, family planning, HIV/AIDS and other infectious disease programs.
- At least 5 years experience in managing donor funded projects and in the design and implementation of overseas health projects.
- The ability to perform at a senior policy level, demonstrated by previous experience in leading the development and implementation of primary health care programs.
- The ability to liaise with senior MOH officials, University Professors and dignitaries, executives of NGOs, FBOs, CBOs, the for-profit business community, and senior members of the Sudan donor community.
- Strong oral and written communication and presentation skills in English.
- Strong Computer skills (word processing, graphic programs and excel spread sheets).
- Familiarity with USAID or other USG administrative, management and reporting procedures and systems.
- The ability to foster team work and to work as a team member.
- Perform as acting COP in the absence of the COP.

Financial/Sub-Agreement/Sub-Contractor Management Specialist

The incumbent will oversee the development, monitoring and evaluation of the proposals submitted to the offeror under for subcontracts and for quick disbursing Grants Under Contract components of the Task Order. The incumbent will serve as the principal point of contact with prospective recipients and is expected to have:

- At a minimum a Bachelors Degree in Business Administration, Finance Commerce or related field. Extensive experience in managing grants or contracts for NGOs may be substituted in lieu of a degree in business, administration or commerce.
- Strong oral and written communication and presentation skills in English.

- Seven years of progressively responsible work experience in managing small grants or sub-contracts with international health NGOS and/or other civil society organizations preferably in the Africa.
- Knowledge of USAID or other USG assistance policies and procedures.
- Skill in organizing resources and establishing priorities.
- Ability to gather data, compile information and prepare reports.
- Strong Computer skills (word processing, graphic programs and excel spread sheets)

Corporate Capability (10 points)

The offeror must provide relevant information to allow the evaluation committee to assess its:

- Demonstrated successful experience in managing and implementing similar programs, preferably in Africa and in post-conflict settings. *(5 points*)
- Timeliness of performance, including adherence to contracting schedules and other time-sensitive project conditions, and effectiveness of home office field management to make prompt decisions and ensure efficient operation of tasks *(3 points)*
- Customer satisfaction, including satisfactory business relationship to clients, coordination among partners, and prompt and satisfactory correction of problems if and when they arose. *(2 points)*

Past Performance (Adjectival)

Past performance sub-factors include quality, cost control, timeliness, and business relations. In evaluating past performance, the Offeror's past performance in using small business concerns under previous contracts will be taken into consideration. The Offeror shall identify five past contracts (within the last three years) or current contracts for efforts similar to the requirement and include contact information as well as information pertaining to problems encountered on the identified contracts and the Offeror's corrective action. "Similar" in this context means in relation to size, scope, and complexity, as well as to a specific subject matter.

In evaluating past performance, USAID shall consider the information provided by the Offeror, as well as information obtained from other sources. Furthermore, USAID shall determine the relevance of similar past performance information.

The past performance references required by this section shall be provided as an attachment to the Technical Proposal.

II. COST PROPOSAL

Although the cost proposal will not be numerically scored, in instances where technical proposals are considered essentially equal, cost may be the determining factor. The overall standard for judging cost will be whether the cost proposal presents the best value to the US Government in relationship to the estimated costs. The cost proposal will be judged on: (i) whether it is realistic and consistent with the technical proposal; (ii) overall cost control

(avoidance of excessive salaries, excessive home office visits, and other costs in excess of reasonable requirements); and (iii) amount of proposed fee.

The cost proposal should include a detailed budget for the three year period including explanatory notes. All schedules necessary to support and explain proposed costs with breakdowns on direct labor, fringe benefits, supplies and equipment, travel and per diem amounts, other direct costs, and indirect costs; personnel costs, allowances and benefits, such as costs associated with resident and short-term personnel; travel and transportation costs, including airfares (destinations and number of trips), per diems amounts, taxis, and car rentals; other direct costs such as rent, equipment, supplies, domestic, and international communications; and indirect costs supported with a Negotiated Indirect Cost Rate Agreement (NICRA) from the cognizant agency, if available. International travel should be identified separately and broken down by destination, number of trips, and number of travelers.